Inter-Local Health Zone and City Based Supportive Supervision for BEmONC and MNCHN Strategies

Experience of Leyte Province and Ormoc City

October 2014

DOH-Regional Office 8/PHO Leyte/Ormoc CHD
With support of
Project for Strengthening Maternal and Child Health Services in Eastern Visayas

Project for Strengthening Maternal and Child Health Services in Eastern Visayas (SMACHS EV Project)

DOH Regional Office 8, with the support of the Japan International Cooperation Agency (JICA), has implemented the SMACHS EV project in Leyte Province and Ormoc City since July 2010. The project aims to accelerate the attainment of the Millennium Development Goals 4 "Reduce child mortality" and 5 "Improve maternal health".

The project purpose is to increase the number of pregnant women and newborns receiving quality safe pregnancy, safe delivery and postpartum care services in the target areas.

One of the five components of the project is to enhance the capacity of health workers at the primary level to provide quality basic emergency obstetric and newborn care (BEmONC) to the people in the communities they serve. The project has supported the training of 27 BEmONC teams and 118 midwives who work at the primary-level facilities that are close to the people in communities. The Provincial Health Office of Leyte and the City Health Department of Ormoc have trained personnel in the rest of the facilities with the support of the DOH. Now Leyte and Ormoc have full coverage of BEmONC services.

Supportive Supervision (SSV) was developed as a mechanism to maintain, improve and facilitate the application of the knowledge and skills for which BEmONC teams and midwives were trained.

MESSAGE FROM ASSISTANT SECRETARY of the VISAYAS OPERATIONS CLUSTER (VOC)

I would like to Congratulate the Project for Strengthening Maternal and Child Health Services in Eastern Visayas (SMACHS EV Project) for this outstanding effort of coming out with a Manual on Inter-Local health Zone and Supportive Supervision. I believe this is the first of its kind in the country and indeed a very useful tool as shown by the outcomes! Thank you, for trailblazing this effort to document the outstanding and true accomplishments of the project. I often say…"If it is not written, it did not happen" So this Manual is a testament to the so many positive things JICA, RO8, LGUs of Region 8 are doing, and what you all can accomplish if you work together!

The Challenge of Public Health is the challenge of social mobilization. Its moving people into one direction to effect the needed change to create better health outcomes. Changing behavior is very difficult to do, but it starts with documenting the good endeavors and convincing other this is the way to go… That is why I always believe documentation is important in all our efforts. Scaling up a good practice is how we hope to improve health practices in Rural Health Units and Hospitals throughout the country to have a positive impact on reducing Infant, Child and Maternal Mortality. Among the many important endeavors that we have to scale up in the Public Health are Essential Intrapartum and Newborn Care (EINC), Service Delivery Network Referral, Inter-Local Health Zone/ Inter-LGU Collaboration and now the Supportive Supervision (SSV) towards a collective quest for continuous quality improvement (CQI). Many of these have been adopted by Region 8 through the assistance of JICA through the SMACHS EV Project.

Congratulations once again to all partners. Cheers and More power!

Keep up the good works!

DR. PAULYN JEAN B. ROSELL-UBIAL, MD, MPH
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FOREWORD

The Department of Health – Regional Office No.8 with the support of JICA has implemented the Project for Strengthening Maternal and Child Health Services in Eastern Visayas (SMACHS EV Project) in Leyte and Ormoc City since July 2010. The project aims to contribute to the attainment of the Millennium Development Goals 4 and 5.

The project supported the training of BEmONC teams and midwives working at the primary level facilities and has developed an Inter-Local Health Zone (ILHZ) and City-based Supportive Supervision (SSV) as a mechanism to maintain and improve the technical knowledge and skills of the trained personnel.

This manual is a reference material to share the ILHZ and City-based SSV experience in Leyte and Ormoc City with those who are interested in introducing something similar in their area. The manual describes the steps for introducing SSV, its benefits, the problems encountered and how they were resolved.

I would like to thank the Japan International Cooperation Agency (JICA) for its continued assistance to Region 8 and for spearheading the development of this manual. I would like also to thank and commend the Province of Leyte and the City of Ormoc health personnel for their cooperation, support and untiring efforts in the implementation of the ILHZ and City-based SSV which is the first of its kind in the region as well as the country.

All of our collective efforts will hopefully contribute significantly to the improvement of maternal and neonatal health care services and reduce maternal and child mortality not only in Leyte and Ormoc City but in the entire region and country .

Jose R. Llacuna, Jr., MD, MPH, CESO IV
Director IV
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ACKNOWLEDGEMENT

This manual has been developed by those who are committed to provide quality maternal and child health care to the people in Eastern Visayas, particularly in Leyte Province and Ormoc City.

Supportive supervision would not have been possible if we did not have dedicated supervisors from the referral hospitals and the Ormoc City Health Department, and support from the Chiefs of Hospital and Chief Nurses. We appreciate and acknowledge their continuous interest and efforts to ensure the quality of services provided through Rural Health Units and District Health Centers under their coverage.

Our special thanks to Asec. Paulyn Jean B. Rosell-Ubial for her support and encouragement in the development of this manual. We also wish to extend our thanks and appreciation to Dr. Rosalie P. Paje of the DOH Family Health Office, Ms. Maika Ros N. Bagunu of BIHC and Ms. Jocelyn T. Sosito of BIHC for their valuable inputs in the improvement of this manual.

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ABBREVIATIONS

Abbreviation	Term in full
BEmONC	Basic Emergency Obstetric and Newborn Care
BHS	Barangay Health Station
CHD	City Health Department
CH	Community Hospital
CHO	City Health Officer
CHT	Community Health Team
CHTF	Common Health Trust Fund
COH	Chief of Hospital
DHC	District Health Center
DHO	District Health Officer
DOH RO 8	Department of Health Regional Office 8
DNS	District Nurse Supervisor
DOH	Department of Health
EVRMC	Eastern Visayas Regional Medical Center
FHSIS	Field Health Services Information System
ILHZ	Inter-Local Health Zone
JICA	Japan International Cooperation Agency
LCE	Local Chief Executive
LGU	Local Government Unit
LPH	Leyte Provincial Hospital
MC Book	Mother and Child Book
MCP	Maternal Care Package
MH	Municipal Hospital
MHO	Municipal Health Officer
MNCHN	Maternal, Neonatal, Child Health and Nutrition
MNDR	Maternal and Neonatal Death Review
MOOE	Maintenance, Operating and Other Expenditures
PCPNC	Pregnancy, Childbirth, Postpartum and Newborn Care
Phil-Health	Philippine Health Insurance Corporation
PHO	Provincial Health Office
PIR	Program Implementation Review
POGS	Philippine Obstetrics and Gynecological Society
RHU	Rural Health Unit
SB	Sangguniang Bayan
SDN	Service Delivery Network
SMACHS EV	Strengthening Maternal and Child Health Services in Eastern Visayas
SSV	Supportive Supervision
TMC	Technical Management Committee
TWG	Technical Working Group

PART A: INTRODUCTION

1. Overview of ILHZ and City-Based Supportive Supervision in Leyte and Ormoc City

Supportive Supervision (SSV) is defined as "the process of guiding, helping, and encouraging staff to improve their performance, providing better quality services, and meeting the needs of their clients according to defined standards of performance"[1].

Inter-Local Health Zone (ILHZ)/City-based SSV was introduced in the Province of Leyte and Ormoc City with support from DOH RO 8 and the SMACHS EV Project in October 2011 as a means to maintain and improve Basic Emergency Obstetric and Newborn Care (BEmONC) technical knowledge and skills. The ILHZ/City-based SSV is used as the operational basis for SSV because of its manageable size. It will facilitate better communication and working relationship between RHUs and hospitals, forming a service delivery network.

SSV is done by supervisory teams of Referral Hospitals and Ormoc City Health Department for the BEmONC teams and midwives working at Rural Health Units (RHUs)/District Health Centers (DHCs) and community hospitals. Initially, SSV was implemented in the project areas, but has now been expanded to the entire province of Leyte and Ormoc City.

Each facility is visited quarterly. The team utilizes SSV tools that were developed for this purpose. When further support is needed for improving the delivery and quality of services, the visit is implemented more often.

Conducting SSV involves preparation, actual visits, and utilization of the results to ensure that the quality of services will keep improving. Therefore, right after the visit, there is an immediate discussion of its result with the facility personnel including the Sangguniang Bayan (SB) on Health or his/her representative to discuss the identified problems and generate solutions to them.

The results can also be utilized to monitor the implementation of MNCHN strategies and identify appropriate interventions to undertake at the ILHZ Level, Provincial Health Office, City Health Department and DOH RO8.

[1]Source: Strengthening Supportive Supervision in the Health Sector, Facilitators Guide, Integrated Family Health Program, 2009

2. Purpose of writing this manual

The experience of ILHZ/City-based SSV has attracted the interest of DOH as well as other regions because this is the first practice of its kind in the country. Many have asked how it is done. Thus, this manual is written to share the experience of ILHZ/City-based SSV as carried out in Leyte and Ormoc, and to stimulate discussion on how to ensure the monitoring of BEmONC services among health managers, MNCHN coordinators, BEmONC trainers and all other stakeholders.

3. How to use this manual

This manual is a reference material for those who are interested in introducing something similar to their area such as regional, provincial and city health management. The manual describes the steps for introducing SSV and gives the reader practical tips to overcome problems that are likely to surface as it is implemented. It also provides benefits and lessons learned from implementing ILHZ/City-based SSV.

This manual is organized in the following manner. The reader can use any relevant part that suits his or her needs. The actual training material is available on request.

Part A: Introduction

Part B: ILHZ and City-based SSV of Leyte and Ormoc City

This part describes the concept of the SSV as well as how it was done, what challenges were encountered, and how they were overcome.

Part C: Linking SSV to MNCHN monitoring

This part describes a trial of DOH RO 8 in utilizing the SSV data for its monitoring of MNCHN strategies.

Part D: Benefits of SSV and lessons learned

This part summarizes the experience and the benefits of conducting ILHZ/City-based SSV as perceived by both the supervisees and supervisors.

Part E: Sustainability

This part explains some mechanisms to establish in order to make SSV sustainable.

Part F: Frequently asked questions

This summarizes main points in a question-and-answer form.

PART B: ILHZ AND CITY-BASED SUPPORTIVE SUPERVISION of LEYTE PROVINCE and ORMOC CITY

1. Background - How the idea of SSV came about

The BEmONC training of the health workers at the primary level is one of the main strategies to reduce maternal and neonatal deaths. In the Philippines, the RHU/DHC-based BEmONC team, composed of one doctor, nurse and midwife each, is trained through the 11-day BEmONC training course to provide better services for mothers and newborns. In addition, midwives working in the same facilities are trained for its midwifery version[2].

The trainers conducted post-training evaluation of BEmONC team to ensure the implementation of the BEmONC protocol. The evaluation revealed many issues that required long-term regular follow-up. Initially, the plan was for the DOH RO 8 and PHO to provide regular follow-up. However, this was not feasible because many facilities required considerable resources, particularly time and manpower.

Incidentally, ten (10) ILHZs in Leyte were established in 2008, although most were not yet fully functional. Meanwhile, PHO Leyte has maintained the designation of District Nurse Supervisors (DNSs) who have a supervisory role on the public health programs delivered at RHUs in the ILHZ. This provided the opportunity for establishing ILHZ-based SSV with the DNS as focal person.[3]

ILHZ-based Supportive Supervision was thus introduced as a mechanism to maintain and improve BEmONC technical knowledge and skills. It is essential to guide and support the trained personnel to effectively perform their duties and improve their performance.

[2] In Leyte and Ormoc City, the midwives working at the BHSs were trained on "Capacity Enhancement on Maternal and Neonatal Care for Midwives" by BEmONC trainers at EVRMC in cooperation with POGS and the SMACHS EV Project.
[3] In provinces where no DNS is assigned, the PHO monitors the MHOs for public health programs. ILHZ-related issues are reported to the TMC Chair and the Chairperson of the Board.

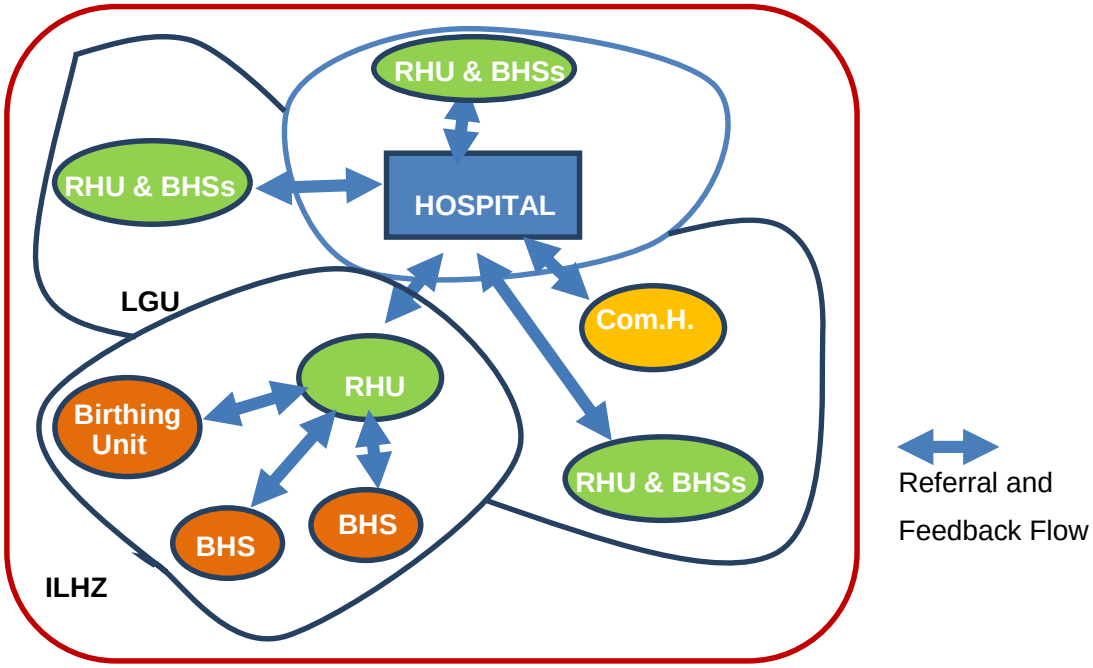
2. Rationale of an ILHZ/City-Based SSV

2.1 What are ILHZs and SDN?

The Inter-Local Heath Zone (ILHZ) is a nationally endorsed unit for local health service management and delivery. It has a defined geographical area, covering several Local Government Units (LGUs), and consists of a core Referral Hospital and a number of primary-level facilities such as RHUs and Barangay Health Stations (BHSs). Individuals, families, communities and health care providers participate in an ILHZ together to assure quality, equitable, affordable and accessible health care with inter-LGU partnership as the basic framework[4].

The Service Delivery Network (SDN) is comprised of public and private hospitals, private birthing clinics, and the RHUs/DHCs and BHSs where services are provided corresponding to their level. Within the service delivery network, the provincial and district hospitals are immediately linked to RHUs/DHCs as referral hospitals. They are located closest geographically to these primary-level facilities.

Figure 1: Typical Structure of ILHZ and SDN



In Leyte, the areas covered by ILHZs and the SDN are basically the same cluster of health facilities wherein the primary BEmONC facilities and a referral hospital form the network. Thus using this platform is practical for establishing the regular SSV as the ILHZ is manageable in size.

[4]Source: Executive order 2005, 31st January 2000, President Joseph Estrada

Ormoc City is equivalent to one ILHZ in terms of size and service delivery. However, the SSV team comes from the Ormoc CHD and has a direct supervisory role over the District Health Centers under its jurisdiction.

2.2 Benefits of ILHZ/City as operational basis for SSV

Conducting an ILHZ/City-based SSV has the following potential benefits:

- It is of a manageable size, having only several facilities within an ILHZ/City.
- It helps promote and maintain the national standards for the BEmONC services in all the facilities.
- It can effect an ILHZ/City-wide solution when common problems across the facilities are identified.
- It helps the ILHZ become functional and strengthens its roles.
- It helps the Ormoc CHD further strengthen its managerial and supervisory roles.
- It strengthens the SDN by improving the referral between RHUs and hospitals as a result of better communication and working relationship.

3. Challenges in introducing and implementing ILHZ/City-Based SSV

Potential challenges include the following:

- *Issue on Administrative Jurisdiction.* Hospitals are under the Provincial Government while RHUs are under Municipal LGUs. The supervision of RHUs is not an inherent function of the hospital staff, and hospitals have no direct authority over the RHUs.
- *Inadequacy of resources*. This includes shortage of trained manpower, transportation and logistics such as office equipment and office supplies.
- *Conflicting schedules* among the SSV team members, i.e., supervisors, and between the supervisors and supervisees.
- *Resistance of supervisees to be supervised.* Negative perception of the supervisee that supervision is a fault finding exercise and disturbs the services at the facility.

The situation varies from one place to another. Thus it is very important to analyze benefits and challenges, and reach a consensus with all stakeholders.

4. Process of introducing ILHZ/City-based SSV

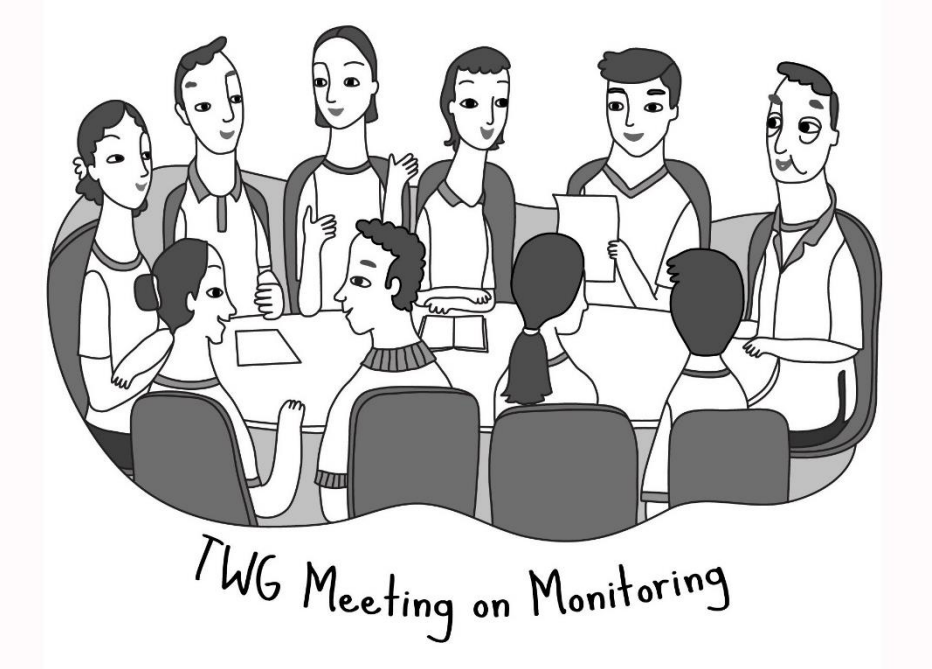
ILHZ-based Supportive Supervision on BEmONC was a new concept and required careful planning and preparations (see Annex 1 for chronological presentation of SSV related activities).

4.1 Analysis of pros and cons, alternative methods prior to presenting a proposal

As discussed in the previous section, the situation varies from place to place. Before proposing this modality, other options were assessed carefully prior to making a decision.

4.2 Creation of a Regional Technical Working Group (TWG) on Monitoring

A Regional TWG on Monitoring was created to come up with the overall monitoring framework of MNCHN strategies in the region, of which SSV is an integral part. The TWG is convened by the DOH RO 8 quarterly (see Part C).



4.3 General consensus on the introduction of the ILHZ/City-based SSV

The final decision was made among all stakeholders, particularly in this case the hospital management, because most of the supervisors would come from the hospital.

Consensus building is an indispensable step to introduce a new system such as an ILHZ-based SSV. It can only be started after all stakeholders are consulted and have discussed potential benefits and challenges.

4.4 Actual preparation at the facilities

The implementation of ILHZ/City-based SSV would depend on the commitment of the hospitals especially the Chiefs of Hospital (COH) and the City Health Officer who would direct the teams to conduct SSV as well as its acceptance by supervisees. Thus, preparations were done both at the supervisor (team at the District Hospital and Ormoc CHD) and supervisee levels (RHUs/DHCs and Community/Municipal Hospital). It was also important to make an overall system to follow up on the implementation of SSV, which is the responsibility of the PHO/Ormoc CHD as well as DOH RO 8.

Supervisor Level (Hospital and Ormoc CHD):

- Training of the hospital team composed of physician, nurse and midwife on BEmONC.
- Inclusion of PHO/Ormoc CHD technical staff as observers during the BEmONC Training.
- Inclusion of DNSs/Ormoc CHD staff as observers during the training on Capacity Enhancement for Midwives on Maternal and Newborn Care.
- Training of hospital BEmONC teams, DNSs and Ormoc CHD technical staff on SSV.
- Orientation of Chiefs of Hospitals and Chief Nurses on SSV.
- Training of PHO ILHZ Coordinators[5] and DOH representatives on SSV.

ILHZ Level

- The ILHZ technical group, of which the Chief of Hospital (COH) is the chairperson, made a collective decision to start the SSV.
- Approval of the Local Chief Executives (LCEs) regarding the conduct of the SSV was solicited and granted.
- Issuance of an Office Order from the COH to the BEmONC Team directing it to conduct SSV.

Supervisee Level (RHU/DHC/CH/MH):

- Ensure the availability of trained BEmONC teams.
- Introduction and orientation on the use of BEmONC Clinical Forms (see "5.1. Tools" below and Annex 2).
- Orientation on SSV (This was conducted together with the orientation on BEmONC clinical forms).

PHO, Ormoc CHD and DOH RO 8

- Assign a responsible person who will monitor the implementation.
- Assign a support staff to the responsible person.

[5] The Leyte PHO has assigned its technical staff to each ILHZ as coordinators.

- Agreement during the 1st Regional TWG on Monitoring attended by the COHs for the hospital BEmONC teams to conduct the ILHZ-Based SSV.
- Issuance of a PHO office order for the ILHZ to organize a SSV Team based on the agreement during the Program Implementation Review (PIR) with all ILHZs.

5. Tools

The following two sets of tools were introduced to establish SSV.

- BEmONC Clinical Forms
- SSV Checklists.

5.1 BEmONC Clinical Forms

The standardized BEmONC clinical forms were developed because no standardized clinical recording forms had existed. These forms are essential in conducting systematic review to assess the quality of services. They cover the following six main areas of BEmONC services (see Annex 2 for actual forms):

a) Antenatal Care
b) Labor Record
c) Partograph
d) Immediate Postpartum
e) Postpartum Care
f) Newborn Care

These BEmONC clinical forms were developed from the BEmONC training materials with the following modifications:

- Additional contents based on the Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC) manual; and
- Additional columns to record four visits to ensure continuity of antenatal, postnatal and newborn care, and to economize by reducing the number of sheets required for a client.

5.2 SSV Checklists

Six SSV tools are currently used with additional feedback and action plan sheets. These were developed based on the national Integrated Monitoring Modules on MNCHN strategies and PCPNC Manual. All checklists can be found in Annex 3 of this manual.

Table 1: List of Checklists for Supportive Supervision

Checklist	Purpose	Content
Checklist 1: Resources	Assess the readiness of a health facility to provide BEmONC services.	Human resources; facility; service delivery; equipment; drugs and supplies; LGU inputs and support; and PhilHealth accreditation
Checklist 2: Records Review	Review BEmONC Clinical records to assess the quality of services.	BEmONC clinical records on antenatal care; labor record; partograph; immediate postpartum care; postnatal care; and newborn care
Checklist 3: Knowledge Application	Assess the level of knowledge and its application by BEmONC teams and midwives.	Observation or interview using guides; performance of BEmONC signal functions
Checklist 4: Clients Interview	Interview clients who delivered at the facility.	Satisfaction; care received during the delivery at the facility; and availability and recording of Mother and Child Book
Checklist 5: Referral	Functionality of referral system	Referral cases; feedback; appropriateness of referral based on the PCPNC manual
Checklist 6: CHT Activities	Monitor and assess the CHT's activities.	Quality of consolidation of monthly reports; CHT monthly meeting; and CHT support and issues
Feedback	Summary of findings	Summary of findings on the following: checklists 1 to 6; checks on maternal and neonatal death review recommendations; action plan of the previous SSV; and updating of action plan
Action plan	Action plan based on the summary above	RHU/DHC staff to make one. Supervisors facilitate the planning.

6. Training

Training of supervisors is an essential step for them to learn the tools, and make the SSV effective. In the case of Leyte and Ormoc, the training was carried out as indicated in Table 2 below. Training manuals for both facilitators and supervisors are available upon request (see Annex 4 for the list of SSV training materials).

Table 2: Training Summary for Introducing SSV in Leyte and Ormoc City

#	Activity	Duration	Facilitator	Materials/Others
1	Facilitators training	1 day with all facilitators, and half a day orientation with each of the facilitators by the project staff*	• SMACHS-EV Project	• Facilitators guide • Presentations • SSV tools; BEmONC clinical forms; SSV scheduling format; field practice observation sheet
2	Supervisors training	3 days including a half-day field trip	• DOH RO 8 • PHO • SMACHS –EV Project	• Participants guide • Presentations • SSV tools; BEmONC clinical forms; SSV scheduling format; field practice observation sheet • Arrangement for field site visit and transport

#	Activity	Duration	Facilitator	Materials/Others
3	Orientation of Chiefs of Hospital and Chief Nurses	1 day each	• DOH RO 8 • PHO • SMACHS–EV Project	• Presentations • SSV tools • SSV plan • BEmONC clinical forms
4	Supervisors training DOH Reps/ ILHZ Coordinators/ other hospital physicians	3 days including a half-day field trip	• DOH RO 8 • PHO	• Participants guide • Presentations • SSV tools; BEmONC clinical forms; SSV scheduling format; field practice observation sheet • Arrangement for field site visit and transport

*Facilitators' training was done in this manner as it was difficult to have another day together because of their busy schedule. Normally it would be carried out in one setting.

Facilitators included:

- DOH RO 8 MNCHN coordinator
- DOH RO 8 Training coordinator
- PHO I
- PHO MNCHN coordinator
- SMACHS Project (MCH Expert)
- SMACHS Project Coordinator

Participants in the Initial Supervisor's Training

- Nine Hospital BEmONC teams (a total of 27 doctors, midwives and nurses)
- Nine DNSs
- Six Ormoc CHD technical staff members

Resources for actual training

- Venues and meals and snacks for three days
- Accommodations for the participants with breakfast and dinner (three people per room)
- Transport for field visits (five vans for half a day)
- Logistics (photocopy of tools, manuals, other materials)
- Projectors, PC, white boards, flip charts, and clipboards for field visits

7. Conducting SSV

This section describes how SSV is currently conducted.

7.1 Frequency

Each facility is visited quarterly. When external support is needed for improving service delivery and quality, the visit is done more often. Both the supervisors and the supervisees agree on the dates of the visit and discuss transportation and other concerns.

7.2 Transportation arrangement

The hospital ambulance brings the SSV team to the facility to visit and fetch them after the SSV. The LGU ambulance may also transport the SSV team back to the hospital. If no ambulance is available, the team takes public transportation and asks for reimbursement of the fare from the MNCHN grant or Hospital Maintenance, Operating and Other Expenditures (MOOE). However, this arrangement is currently under review for sustainability of SSV (see Part E).

7.3 Preparation for conducting SSV

1) Confirm the schedule with the facility to visit.
2) Set a date so that a majority of the team members can take part in the visit. It is advisable to make the schedule of the visit at least two weeks in advance so that the Chief Nurse/Chief of Clinics can make the duty roster, taking the SSV team's schedule in mind.
3) Prepare the tools (all necessary forms for SSV) and assign the checklists among the supervisors.
4) Bring the last SSV results and a copy of the action plan of the facility to visit.
5) Make a summary of the referral data of the facility to visit.

Important role of the Chief Nurse and Chief of Clinics/Senior Resident Physician

There is an agreement with the COH that the SSV team shall <u>conduct the visit during their working hours</u>. Thus it is mandatory to coordinate with the Chief Nurse and Chief of Clinics/Senior Resident Physician on the arrangement of their scheduled duties. A copy of the SSV schedule is given in advance.

7.4 Steps in conducting SSV

<table>
<tr><th colspan="3">Steps</th></tr>
<tr><td>1</td><td>Greet the RHU/DHC staff and explain the purpose of the visit. Also explain the purpose to the clients and ask for their patience and cooperation.</td><td rowspan="2"> 
</td></tr>
<tr><td>2</td><td>Greet the Mayor/SB on Health/ LGU official and request him/her to join the SSV or at least the feedback sessions.</td></tr>
<tr><td rowspan="4">3</td><td>Each supervisor carries out his/her respective tasks using the corresponding checklist with the facility staff.
The following will take place simultaneously.</td><td rowspan="3"> 
</td></tr>
<tr><td>• Go around and observe the physical setup in and outside the health facility.</td></tr>
<tr><td>• Ask the staff to show BEmONC Clinical records of a patient.
• Go through randomly selected clinical forms, preferably postnatal cases to assess intrapartum care as well as the continuity of care.</td></tr>
<tr><td>• Observe skills, practices, and procedures of the staff if possible when there is a client. If there is no client, do the simulations and interview.
• Do not point out mistakes in front of the client unless it is posing a danger to her/him.
• Give feedback to the staff and coach immediately after observing practices.</td><td>  </td></tr>
</table>

	• Ask the staff to show drugs, supplies, and equipment inventories. Confirm the availability of those materials.	
4	After completing all checklists, supervisors meet to check the accuracy and consistency of information gathered. Using the checklists, discuss and make a summary, completing the feedback sheet.	
5	Call all the staff and LGU official for the feedback that includes the following: • Discuss both positive and negative findings; • Review the previous supervisory report and action plan, and note the achievements; • Facilitate the formulation of an action plan based on the identified problems; • Solicit the support and commitment of the LGU official attending the session; • Agree on the schedule of the next SSV.	

Important!! A LGU representative, most preferably the Sangguniang Bayan on Health, must be present if at all possible, so that the non-technical concerns of the RHU staff can be addressed in the presence of SSV teams.

7.5 Activities after SSV

The following are the tasks that the SSV team should perform after the team's return to the hospital.

1) ILHZ Level:

a) The SSV team gives feedback and submits a report to the COH (TMC Chair).
b) The COH and the SSV team discuss what they should do to help the facility implement its action plan.
c) The DNS consolidates the report and keeps a file at the ILHZ office.
d) The COH/DNS submits hard and soft copies of the consolidated report to the PHO through the MNCHN Coordinator.
e) The DNS prepares results for discussion at the ILHZ TMC meeting.
f) The results are shared during the TMC meeting to discuss the problems identified and the solutions to them.
g) The DNS gives feedback of the results of the ILHZ TMC meeting to the SSV team.

2) PHO Level:

a) The ILHZ Coordinators review the completeness and accuracy of the ILHZ consolidated SSV report (see the box on ILHZ coordinators in Section 9, Part B).
b) The data are entered and consolidated using the SSV Database.
c) The data are analyzed and a report is prepared.
d) Recommendations are made for enhancement of the quality of services based on the results of the report.
e) The results are discussed in an appropriate venue such as a PIR, MNDR and TWG meeting (see Part C, 2 for TWG meeting).
f) The SSV report is submitted to DOH RO 8.

3) Ormoc CHD Level:

a) The SSV team gives feedback and submits a report to the Ormoc CHD.
b) The Ormoc CHD and the SSV Team discuss what they should do to help the facility implement its action plan.
c) The MNCHN coordinator submits hard and soft copies of the consolidated report to DOH RO 8.
d) The results are shared during PIRs and Ormoc CHD staff meetings to discuss the problems identified and the solutions to them.

8. Challenges encountered in conducting SSV and how they were overcome

Conducting SSV regularly is not an easy task, but it is possible. DOH RO 8 and the Project organized a quarterly TWG meeting with COHs and Chief Nurses of each hospital to discuss the implementation of SSV and find solutions when problems are identified. The following is a list of problems encountered in Leyte and Ormoc and how they were resolved.

a) ***Conducting SSV during working hours.*** At the start of SSV, the team members conducted the SSV during "off-duties" as a result of lack of understanding and coordination among the hospital staff. To address this problem, Chief Nurses were oriented on SSV and practical solutions were agreed upon. This includes prior scheduling by the SSV team and sharing of these schedules with Chief Nurses and Chiefs of Clinics before the finalization of the monthly staff schedule. If the staff members conduct SSV during their "off-duties", they will be given a compensatory day-off to be utilized within a month.

b) ***Coordination of schedule between Supervisors and Supervisees.*** During the SSV visit with the facility, the team agrees on the schedule of the next visit with the RHU/DHC staff members. The DNS/Ormoc CHD supervisors confirm the schedule a few days before the visit. However, if there are conflicting activities, rescheduling is mutually agreed upon. This situation is a recurring concern that requires patient negotiation and cooperation. SSV may be carried out if the MHO/DHO or a nurse is present with the midwives, provided that the SSV findings are shared among all the RHU/DHC staff members.

c) ***Transportation issue.*** At the start of the implementation, transportation was a major problem. The initial agreement with the COH was to use the hospital ambulance. However, there were concerns in the implementation of this agreement because the main use of the ambulance is to transport people facing an emergency. During the TWG meeting, this issue was addressed and options were discussed. Here is the solution: the SSV team will go back to the hospital or another facility and use the municipal ambulance or any municipal vehicle. If both means of transportation are unavailable, the SSV team will use public transport and the cost will be reimbursed by hospital management/ ILHZ.

d) ***Adequacy of BEmONC Clinical Forms and SSV Checklists***. After the orientation, the project provided initial sets of the forms to facilities and hospitals to commence SSV with the agreement that the LGUs and the hospitals will duplicate the BEmONC forms and the SSV checklists. The PHO kept urging LGUs to duplicate the forms using

PhilHealth revenues and capitation fund because most of the facilities had difficulties in the duplication. As a result, the majority of the LGUs are now duplicating the forms. As for the SSV checklists, hospitals were reminded to use the ILHZ Common Health Trust Fund (CHTF) or use hospital funds. The PHO also provided the SSV checklists to all hospitals. Presently, most of the hospitals are able to provide their own SSV checklists.

e) ***Shortage of manpower in the hospital and Ormoc CHD***. Some supervisors were unable to participate in SSV because their absence will hamper the services of the hospital and Ormoc CHD. This situation often resulted in the disruption of the SSV schedule. In the TWG meeting, it was decided that at least one BEmONC trained member should join SSV. Another recommendation was to enlarge the pool of supervisors by training additional personnel on SSV including PHO ILHZ coordinators, DOH representatives, and other hospital staff members, preferably obstetricians and pediatricians. The latter was implemented in October 2012.

f) ***Resistance to adopt the new clinical and referral forms***. Prior to SSV, clinical recording was minimal and no standard format existed. The introduction of the BEmONC clinical and referral forms required a significant change in the practice of relevant personnel. This was met with initial resistance resulting in incomplete recordings. With consistent coaching and mentoring during SSV as well as ILHZ TMC meetings, the new practice was gradually accepted.

g) ***Disinclination among elder health personnel to be supervised.*** Some senior RHU staff members were disinclined to be supervised particularly by younger supervisors because, they said, that they would soon retire and the supervision should focus on younger supervisees. The SSV supervisors mastered the content and avoided the use of the checklists in the presence of the senior RHU staff members to make the visit more acceptable and less threatening to them.

9. Monitoring of SSV implementation

It is necessary to monitor SSV implementation at each ILHZ so that it is conducted regularly and, more importantly, the results are discussed and services improved. The monitoring also serves as a reminder and support to the SSV teams, because it shows that people are interested in it.

PHO Leyte monitors the implementation of SSV in the following manner:

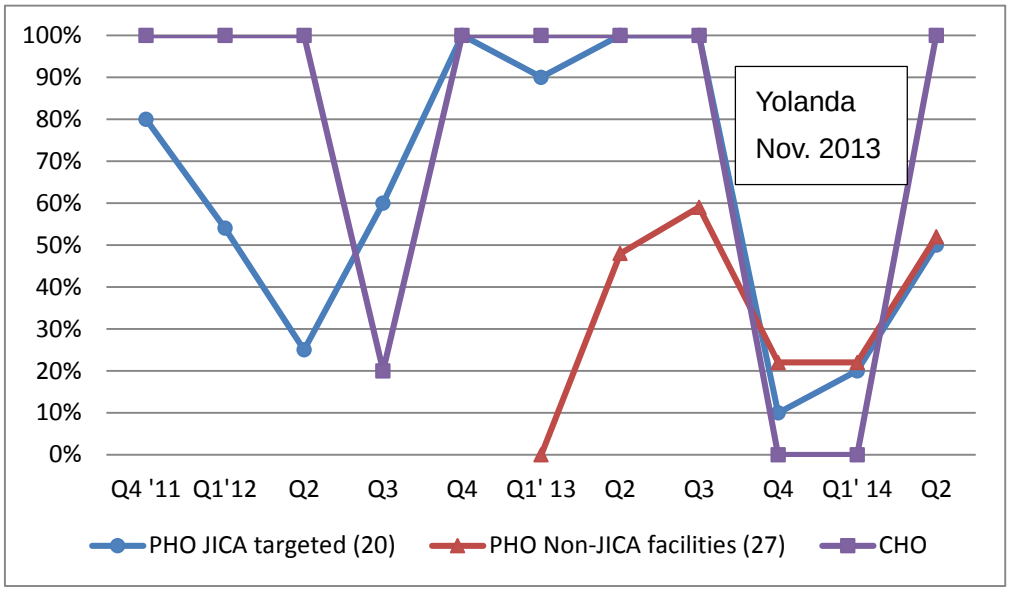
- The PHO MNCHN Coordinator, along with the ILHZ Coordinators, receives the quarterly SSV schedule from the DNS.
- The DNS or ILHZ Coordinator informs the PHO MNCHN Coordinator of the actual SSV conducted.
- The SSV results per municipality are consolidated by the DNS using a monitoring tool developed through the project. Soft and hard copies are submitted to the PHO through the ILHZ Coordinators.
- The ILHZ Coordinators submit the report to the PHO MNCHN Coordinator after checking it for completeness and accuracy.
- The MNCHN Coordinator receives all SSV results and reviews, consolidates in a data base, and analyzes the data.
- The PHO-consolidated data is submitted to DOH RO 8.
- The SSV's status is shared at the ILHZ level by the COH during TMC meetings and by the PHO during PIRs and Quarterly Meetings with DNSs and PHO technical staff. In other words, it is shared at as many opportunities as possible.

Roles of ILHZ Coordinators and Their Alternates

The roles of ILHZ coordinators and their alternates on SSV implementation are as follows:

a. Coordinating the schedule and making sure that it is implemented.
b. Collecting SSV reports and checking their quality. Items to check include consistency of the information in the reports and proper filling of checklists.
c. Validating the data on ILHZ monitoring tools with the SSV reports.
d. Helping SSV teams by participating in actual SSV when possible; discussing the result of SSV in an ILHZ meeting

Figure 2: Implementation of SSV (2011–2014)



Note: Leyte Province and Ormoc City were severely affected by the super typhoon Yolanda on November 8, 2013. SSV has resumed as the health services returned.

10. Feedback and utilization of results

This will happen at various levels, as described below. The primary use is for the facilities to review their practices and improve their services. However, the data can also be utilized to monitor the implementation of BEmONC services and MNCHN strategies.

10.1 Feedback on site and action plan

Towards the end of the SSV when all supervisors have completed all checklists and made a summary, the RHU/DHC staff and LGU representative are given the feedback including both positive findings and areas that need to be improved. The SSV Team Leader or DNS facilitates the formulation of the action plan based on the identified problems, prioritizing issues that can be addressed within the capacity of the RHU/DHC staff. In Leyte, commitment of the LGU representative is solicited to support the proposed solutions.

10.2 Utilization of results

There are various mechanisms for sharing and utilizing the results of the SSV to discuss and address the issues identified as listed below:

Table 3: Utilization of Results at Different Levels

	Level	Utilization of Results
a)	Inter-Local Health Zone	• SSV results of each facility are discussed as part of the regular agenda of the Technical Management Committee (TMC) Meeting. The TMC Chair also follows up on the previous action plan to see if the plan was complied with. • During quarterly MNDR • During ILHZ PIRs
b)	Provincial Health Office	• SSV results of each facility are discussed with PHO II/I, Chief Technical and ILHZ Coordinators on the following occasions: - Technical Section Meeting – monthly; - Provincial Health Summit – presentation to LCEs; and - MNDR. • The Provincial Health Officer comes up with recommendations for improving SSV as a system based on SSV results.
c)	City Health Department	• SSV results are discussed with CHO II/I and other technical personnel on the following occasions: - Meetings with District Health Office staff; - Biannual City PIR; and - MNDR. • The City Health Officer comes up with recommendations to improve SSV and BEmONC implementation.
d)	DOH RO 8	• SSV results are presented on the following occasions: - Regional Forum (e.g., Regional MNDR and other consultative meetings); - Technical updates during training, orientations, and the like; and - Regional Technical Working Group on Monitoring meeting.

Steps for Establishing a System of ILHZ/City based SSV

1. Analyse pros and cons, and discuss alternative methods on monitoring
2. Create a Regional TWG on Monitoring to formulate the overall framework for monitoring of MNCHN strategies
3. Obtain general consensus on the introduction of the ILHZ/City-based SSV
4. Train the selected hospital staff on BEmONC
5. Develop necessary tools
6. Orient the hospital management on SSV
7. Train Supervisors
8. Conduct SSV
9. Monitor the SSV implementation through regular TWG meetings.
10. Address problems as they emerge in order to improve the system
11. Use the information gathered through SSV at all levels

PART C: LINKING SSV to MNCHN MONITORING

1. SSV as a complementary mechanism in monitoring MNCHN strategies

The DOH formulated an integrated MNCHN Strategy in 2008 to guide the development, implementation, and evaluation of various programs aimed at women, mothers, and children with the ultimate goal of rapidly reducing maternal and neonatal mortality in the country. It also serves to guide the engagement, assistance, and empowerment of local government units (LGUs) and other partners in rapidly achieving this goal.[6]

BEmONC training is a major activity to enhance the capacity of health personnel regarding the reduction of maternal and neonatal mortality. As primary BEmONC services were new, it was necessary to give more frequent follow-up to incorporate the services into daily practice. This is how SSV came about in Leyte and Ormoc. At the same time, SSV tools are made in accordance with DOH monitoring modules; therefore, data collected through SSV can be used to monitor the MNCHN strategy at the city, provincial, and regional levels.

2. Regional Technical Working Group (TWG) on monitoring

2.1 Members

A Regional TWG is formed of the following:

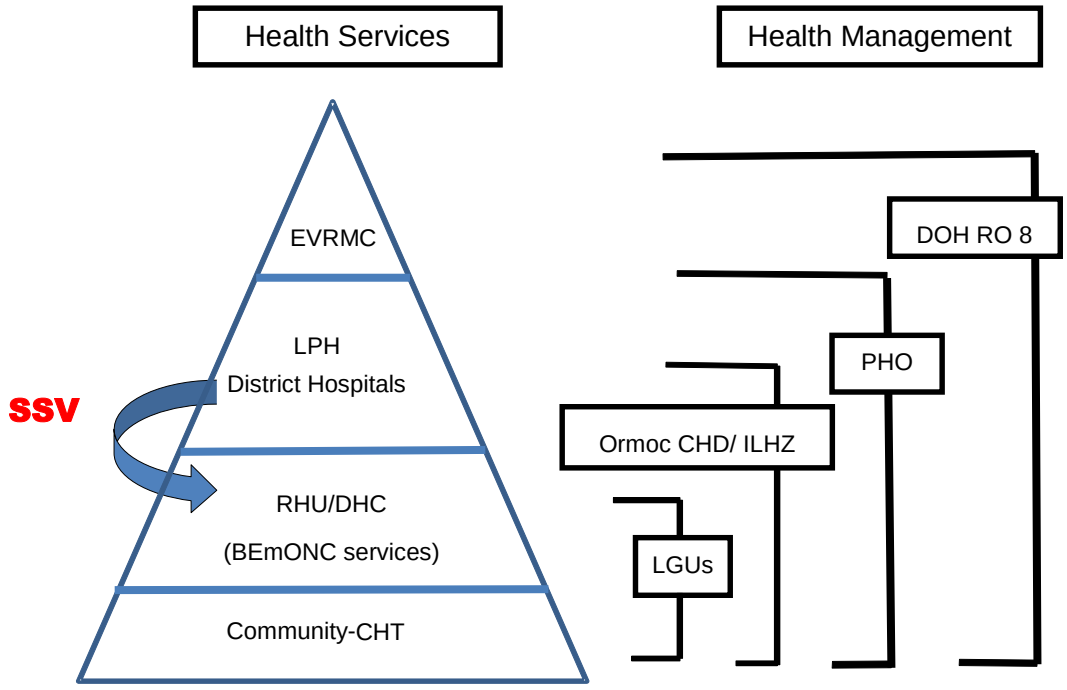
- Assistant Regional Director
- Provincial and City Health Officers
- Hospital Chiefs
- Regional, Provincial, and City MNCHN Coordinators

2.2 Roles and functions

The role of the Regional TWG is to come up with the overall monitoring framework in the region, plan activities, and monitor their implementation. It is also a platform to discuss the results of SSV and to address issues. SSV is conceived as an integral part of the overall monitoring system of MNCHN strategies.

[6] Source: DOH AO No. 2008 – 0029. Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality, dated September 9, 2008

Figure 3: Overall Framework of Monitoring



2.3 Frequency of TWG meetings

The DOH RO 8 convenes the Regional TWG quarterly to discuss SSV status, issues, and implementation problems and to plan with the group on solutions. It also discusses the referral system's functionality, issues, and interventions.

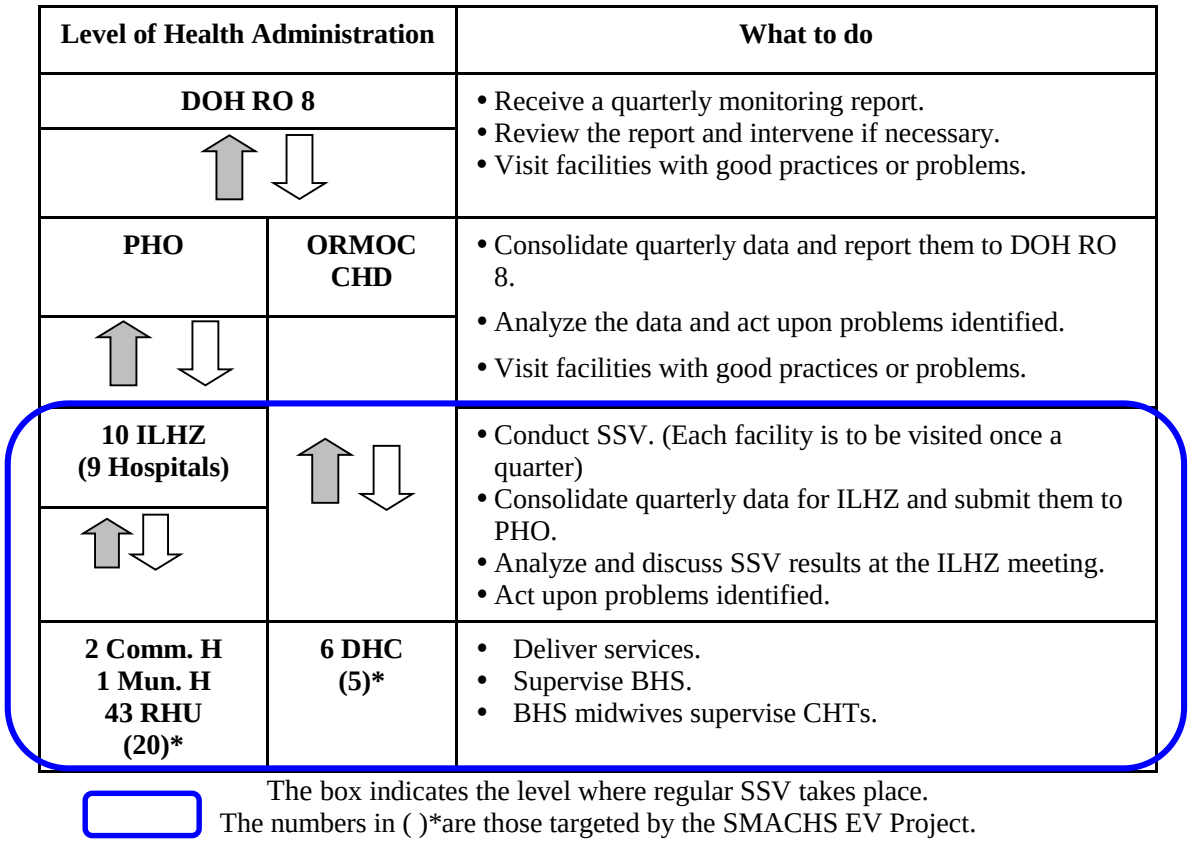
3. Monitoring system from ILHZ/Ormoc CHD to DOH RO 8

3.1 Concept of the system

The respective ILHZ/Hospital BEmONC SSV teams consolidate data from the RHUs and submit the report to the Provincial MNCHN Coordinator through the Provincial ILHZ Coordinators. The Provincial MNCHN Coordinator consolidates the data from the ILHZs and submits the report to the Regional MNCHN Coordinator at DOH RO 8. Likewise at the PHO level, SSV data is analyzed, and problems are acted upon. The PHO visits the RHUs with good practices and identified problems that are beyond the facility's capability to address.

The Ormoc CHD consolidates the data from the DHCs and submits the report to the Regional MNCHN Coordinator at DOH RO 8.

Figure 4: SSV and MNCHN Monitoring System



The box indicates the level where regular SSV takes place.
The numbers in ( )*are those targeted by the SMACHS EV Project.

3.2 Set-up of DOH RO 8 for monitoring

It is important to assign responsible people at each level with clear tasks in order to make the system function.

Table 4: Responsible People

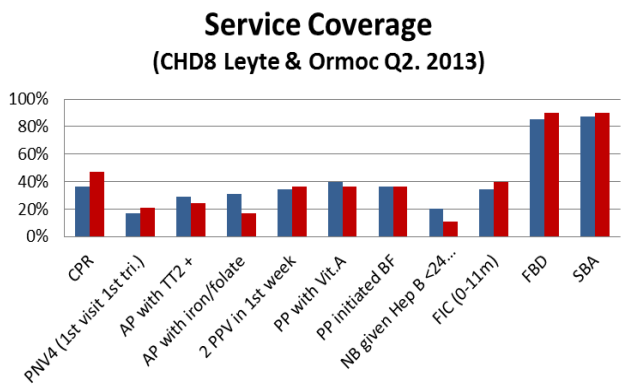
	Level	Who	Tasks
1	DOH RO 8	• Regional MNCHN coordinator • SSV point person	• Overall monitoring of SSV • Follow-up SSV implementation of PHO and ORMOC CHD; and data collection, entry and management
2	PHO	• Provincial MNCHN coordinator • ILHZ coordinators	• Provincial monitoring on SSV and data collection; report to DOH RO 8 • Follow-up SSV implementation and reports
3	ILHZ	• DNS	• Coordinating a schedule for SSV; data entry to SSV database; and report to COH and PHO through the ILHZ coordinator
4	Ormoc CHD	• City MNCHN coordinator	• Coordinating a schedule for SSV, data entry to SSV database; and report to DOH RO 8

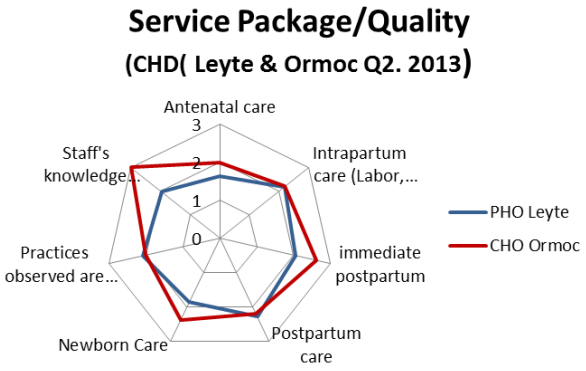
3.3 Database and regional report

Data generated from the SSV are shared during Regional/Provincial/City PIRs and utilized for Regional/Provincial/City planning purposes. To this end, the SMACHS EV project helped DOH RO 8 develop a SSV database, which is shared with the PHO and Ormoc CHD.

The PHO and Ormoc CHD prepare a report, which is presented during the quarterly TWG meeting. DOH RO 8 generates a report from the database using the reporting template.

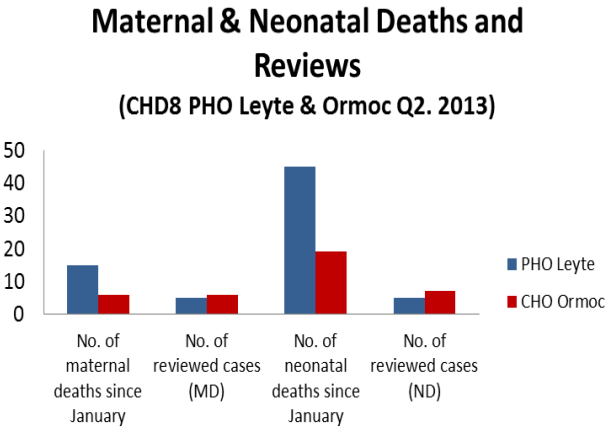
Figure 5: Examples of Outputs from SSV Database of DOH RO 8





Performance of Skills by Midwives (CHD8 Leyte & Ormoc Q2.2013)

Item	Performance	How many facilities	
IE & Partograph	Performed	37	77%
AMTSL	Performed	36	75%
ENC	Performed	37	77%
IV insertion	Performed	34	71%
Suturing	Performed	34	71%
Newborn resuscitation	Performed	10	21%



The above data indicate the need to improve the coverage of some public health programs, the quality of ANC relative to other services in Leyte, and the application of knowledge and skills in the practice in Ormoc. They also show that it is necessary to encourage the use of the partograph and conduct maternal and neonatal death reviews. With this analysis, each level can plan needed interventions.

3.4 Challenges encountered with the database and how they were overcome

a) Delay of FHSIS reporting

The SSV database is supposed to incorporate selected MNCHN indicators from the FHSIS for the same quarter at each facility. However, as the FHSIS tends to be delayed, it has become difficult to consolidate timely data on SSV. Therefore, the indicators are reported as previous quarter outputs together with SSV data in the TWG meeting.

b) Not all have access to PCs and internet connections.

In this case, the DNS sends a hard copy of the SSV reports and reporting forms, and PHO enters the data. It is hoped that this situation will improve in the near future to ease data exchange.

PART D: BENEFITS of SSV and LESSONS LEARNED

1. Positive outcome of SSV

The major impact of SSV implementation in Leyte and Ormoc City was *the establishment of a regular monitoring system* and the strengthening of ILHZ functionality. Other positive outcomes were also observed as follows:

1) For the Health System
   - It has established a functional monitoring system covering all primary facilities and linking health management.
   - It has improved referral flow, facilitating better communication between hospitals and primary facilities and improving staff knowledge regarding which cases to refer. Primary facility personnel feel that it has become easier to refer clients, and hospital staff members are more appreciative of the reasons for referral as they are also trained on BEmONC. At the same time, the hospital staff members observed that referral is done in a timelier manner.

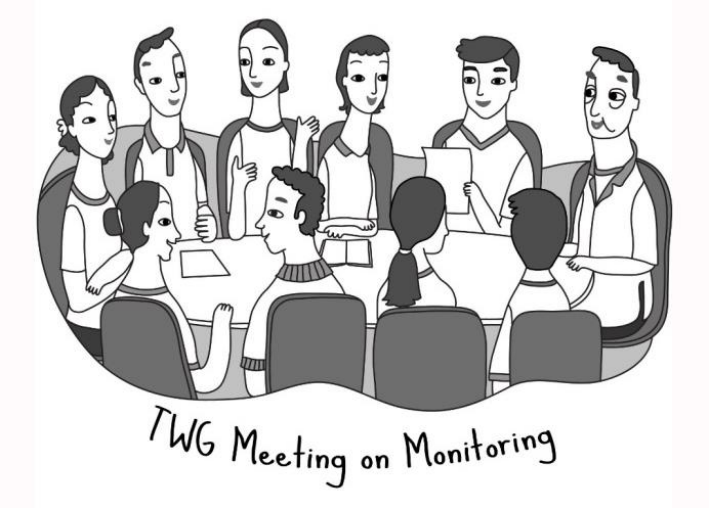
2) For Health Facilities
   - SSV helped to establish the routine use of standardized BEmONC clinical forms aligned to the PCPNC Manual.
   - RHUs and DHCs are now more motivated to improve their services despite the initial resistance to SSV.
   - Provincial and District Hospitals have improved their case management as they now have staff trained in BEmONC who also supervise the Community/Municipal Hospital and RHUs.
   - SSV provides opportunities for the hospital staff members to get first-hand information on RHU practices and problems, providing them with insights and better understanding to improve practices at the primary level.
   - SSV helped identify problem areas in infrastructure, equipment, and emergency supplies, thus facilitating solution-oriented action.

3) For the Inter-Local Health Zone
   - Through SSV, the roles and functions of the ILHZs have been strengthened through implementation of concrete activities.
   - The ILHZs support the duplication of BEmONC and SSV forms, and some provide emergency drugs.

- It has developed a system that facilitates the involvement of other programs-in-charge. For example, the District Sanitary Inspector joins the SSV in some ILHZs.
- Since communication among the facilities was enhanced, the ILHZ has strengthened its role, resulting in an improved referral system as well.
- The ILHZ was able to organize hands-on training for the RHU staff based on SSV results to enhance their capacity by allowing the concerned health workers to go on duty in the District Hospital.
- The supervisory role of the District Nurse Supervisors (DNSs) to the RHUs was better defined.
- Supervisors' knowledge and skills were enhanced.

4) For the PHO/Ormoc CHD
   - SSV results are utilized for planning purposes such as Health Investment Planning.
   - Problematic areas are prioritized for monitoring and technical assistance, and issues and possible solutions are discussed during PHO/Ormoc CHD meetings.
   - Good practices are identified for sharing and possible replication in other RHUs/ILHZs/DHCs.

5) For the DOH RO 8
   - SSV results are utilized for planning purposes, allocating budget for BEmONC training, monitoring, and the purchase of medicines and supplies as augmentation for BEmONC facilities.
   - Facilities with identified problems are prioritized for monitoring visits and technical assistance. Furthermore, technical problems are addressed in the TWG meeting (e.g., checking of hemoglobin level and blood typing during prenatal exam).
   - Good practices are identified for sharing and possible replication in other provinces. SSV was discussed during a Regional MNCHN Consultative Meeting.



Actions! Actions!

SSV will not be sustainable unless SSV team members, managers, and most importantly, supervisees regard it as useful. The following are examples of actions taken as a result of SSV.

Example 1:
In Carigara ILHZ, SSV revealed that no facilities had emergency drugs such as magnesium sulphate. Thus the ILHZ purchased the drugs using the Common Health Trust Fund and supplied them to all facilities. Since then, all facilities in the ILHZ have the drugs at all times.

Example 2:
All RHUs have accepted the use of standardized BEmONC clinical forms. The RHU/DHC personnel acknowledge that these forms help them provide essential care to their patients.

Example 3:
The records review during SSV revealed that none of the facilities were examining urine during antenatal care and labor. The PHO decided to provide them with urine strips to screen urine for protein and sugar for timely identification of women at risk. It would be ideal if each facility could purchase its own supplies using PhilHealth capitation fund or reimbursement.

Example 4:
The records review revealed that many women were not screened for anemia during the antenatal period. The DOH RO 8 and the PHO/Ormoc CHD discussed how to address this situation. As a result of advocacy, some development partners provided RHUs with hemoglobinometers. DOH RO 8 also distributed them to some RHUs.

Example 5:
SSV has a positive effect on hospital practices. Many hospitals introduced partograph for monitoring labor.

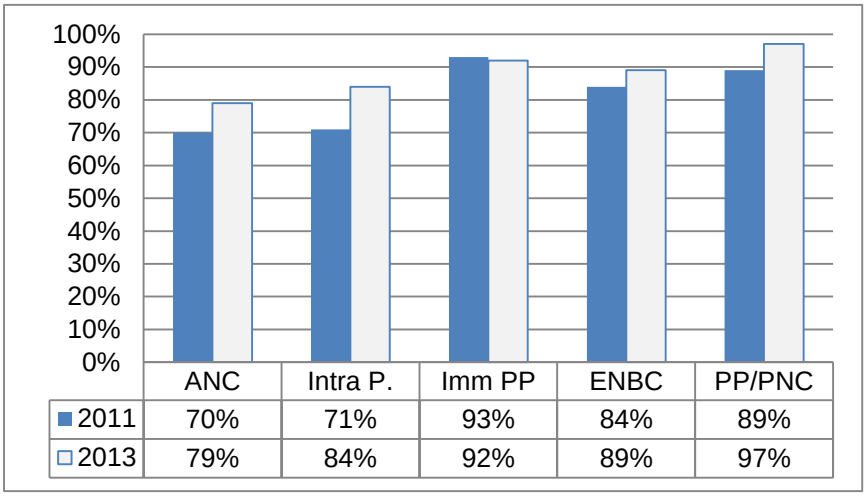
Example 6:
Referral of pregnant women in labor has improved. Partograph is now regularly included in the referral documents in most RHUs/DHCs.

Has SSV really contributed to improve BEmONC services at RHUs/DHCs?

As the Project is not a research project, it is difficult to prove the effects of SSV scientifically. However, periodic assessments indicate that SSV has positive influence in maintaining and further improving their knowledge and skills.

Comparison of assessment results in 2011 and 2013 (25 BEmONC teams)

Observations of Skills by Skill area



	ANC	Intra P.	Imm PP	ENBC	PP/PNC
2011	70%	71%	93%	84%	89%
2013	79%	84%	92%	89%	97%

ANC: Antenatal care, Intra.P: Intrapartum care, Imm.PP: Immediate Postpartum, ENBC: Essential Newborn care, PP/PNC: Postpartum and Postnatal care

Source: Second Assessment of Skills and Knowledge of BEmONC Teams SMACHS EV Project IC Net/HANDS, October 2013

2. Lessons learned

Through the experience in Leyte and Ormoc, we have learned some important lessons. These include the following:

a) It requires careful planning to introduce a new system like SSV. Consensus building among stakeholders is essential. The experience of Leyte and Ormoc showed that the SSV implementation went well because of the coordination and mutual agreement among all stakeholders (RHU/DHC/CH/MH, District Hospitals, PHO/Ormoc CHD, and DOH RO 8).

b) Regular monitoring is the key to ensuring the implementation of a new system by addressing emerging problems and improving and adapting the system appropriate to the actual situation. In this case, a Regional TWG on Monitoring was established and met regularly three to four times a year.

c) SSV results should be reflected in the planning of PHO/Ormoc CHD/DOH RO 8. Planned activities are incorporated in the investment plans such as the Province-wide Investment Plan for Health/City-wide Investment Plan for Health of Leyte and Ormoc City and in the Annual Work and Financial Plan of DOH RO 8. In ILHZs, the Work and Financial Plan includes the duplication of forms and travel allowance to support the conduct of SSV.

d) A database is very important in a system like SSV to help in the analysis and the redirection of interventions to improve maternal and neonatal care services. The SSV database has been developed and is used currently.

e) The involvement and support of the LCEs is essential in the implementation and sustainability of SSV. The passage of a policy would provide official endorsement of the conduct of SSV. In Leyte, the Provincial/Municipal LCEs approved a joint resolution to support SSV.

f) The challenges in the implementation of ILHZ/City-based SSV include transport, forms, and hospital staff shortage (see Part B, 8). Each problem should be addressed as soon as it is identified so that it does not discourage the SSV teams.

3. Stakeholders' opinions on SSV

SSV depends on people who actually implement it. A simple inquiry was made on September 2013, and the results are summarized in the following table.

Table 5: Feedback of People Involved in SSV

Respondent	Question	Response
SSV team members (N = 32)	Do you think SSV is useful for improving the services at the primary level?	All replied "Yes."
	Have your own practices changed since becoming a supervisor?	All replied "Yes." Many indicated that teaching others as part of SSV helped them upgrade their knowledge and skills.
	Does your hospital use a partograph?	Thirty replied that they use the partograph in the hospital. Of these, 10 reported that all personnel in the maternity ward use it (Note: the partograph is not used in the hospital, and the use of partograph is the result of the SSV team's initiative.).
	What are the challenges to continue the SSV as we do now?	Shortage of transport (11); coordination of schedule (5); and negative attitude among staff at RHUs/DHCs (3), etc.
	What would help address such challenges?	Creating and following a schedule (6); refresher training (6); increasing hospital staff (2); and vehicle (2), etc.
	What support do you need to sustain SSV?	Payment of meals and transport allowances (11); incentives (6); and refresher training (3), etc.
Chiefs of Hospital (ILHZ TMG chairs), ORMOC CHD (N = 11)	Are the SSV implementation and results regularly reported and discussed at ILHZ meetings?	Shared in all ILHZ meetings (2); only in the ILHZ TMC meetings (8); only when there are problems (2)
	Do you believe SSV is helping in any way to improve the provision and quality of basic maternal and neonatal care at facilities like RHUs/DHCs?	All replied "Yes." The majority indicated that SSV is helping to improve the provision and quality of BEmONC services. It also helped improve documentation and supplies inventory.
	What is the impact of SSV on your hospital, if any?	It has helped improve referral (4). All indicated that the sharing of SSV results helped the planning of ILHZ and improved communication among hospital staff. One reported that although SSV is needed and useful, it further constrains the hospital.
	Provide examples of how SSV helped the ILHZ improve services.	Referral has improved (10); increased deliveries at the primary level (4); improved the quality of services (5); and reduced maternal and neonatal mortality, etc.
	Is it worthwhile to continue, considering the required inputs of the hospital to the activity?	All replied "Yes." All reported that SSV should continue for improving the quality of services. One said that she wanted to continue, but it would depend on the situation because the hospital does not have enough staff.
RHU/DHC BEmONC teams (N = 66)	Do you think SSV is useful for your facility for improving the services at the primary level?	All replied "Yes." SSV helps improve the quality of services (17); improve knowledge and skills (15); and helps monitor their own performance (10). Some also mentioned that referral has improved. Others reported that SSV forces them to do what they should be doing.
	Views on SSV	The majority stated that SSV should continue even after the end of the Project. Other opinions were to improve the capacity of supervisors (2) and improve scheduling (2).

PART E: SUSTAINABILITY

The sustainability of SSV is a challenge. Leyte Province has expanded the implementation of SSV province-wide since all RHUs are BEmONC facilities. Likewise, the Ormoc CHD included all the DHCs. This would imply the need for more resources. Thus, LGU commitment and support is vital. Some measures have already been undertaken for policy and resource allocation.

1. Policy framework for ILHZ-based SSV

A policy on the conduct of SSV was formulated and approved during the 2nd Joint ILHZ Board and TMC meeting in August 2013, entitled "A resolution to support the regular conduct of Maternal and Neonatal Death Review (MNDR), Supportive Supervision (SSV), and Program Implementation Review (PIR)" for the 10 ILHZs of Leyte Province.

2. Resource allocation

This is a crucial issue to sustain the activity. We need to explore several mechanisms for this.

a) Funding SSV through the CHTF of the ILHZs

The PHO, with the support of the SMACHS project, is working hard to help each ILHZ to establish a functional CHTF. Once this is done, the ILHZ Work and Financial Plan will include funds for the duplication of the forms and the conduct of TMC meetings, including possible incentives for the supervisors.

b) Payment of travel allowance through PHO accounting and auditing rules

Reimbursement of actual cost of transportation and meals of the SSV team and PHO ILHZ Coordinators can be charged to the MOOE of the hospitals and PHO, respectively.

c) Regional input

DOH RO 8 appropriates funds for monitoring visits and for the quarterly conduct of the Regional TWG on Monitoring. This is reflected in their Work and Financial Plan.

3. Motivating SSV teams

Keeping the SSV team members motivated is an important issue to address if SSV is to continue. Some measures being proposed are as follows:

a) Incentives for SSV teams through the CHTF of ILHZs

When CHTF is established, each ILHZ can include some incentives in their work and financial plans.

b) Awarding of SSV teams

As a way to motivate SSV teams, the PHO plans to have an annual award for best performing teams. This is yet to be instituted as the process was disrupted by Typhoon Yolanda in November 2013.

c) Dissemination of SSV

SSV teams should be encouraged to share their experiences with others through their presentations. DOH RO 8 should try to involve them when there are appropriate meetings at the regional and national levels.

d) Recognition of SSV teams' efforts

Recognition of good practices and performance of SSV teams even during regular activities or meetings provides motivation and boosts team morale.

e) Feedback of the results of the TMC meeting to the SSV team

Knowing how the results of SSV are utilized will sustain the interest of the SSV team members, therefore, feedback should be given on what interventions were discussed and recommended.

PART F: FREQUENTLY ASKED QUESTIONS

This section discusses answers to questions often asked about SSV.

a. Can hospital BEmONC teams be supervisors?

Yes. This question is often asked because of the notion that supervisors should be superior to those being supervised. How can a BEmONC team member supervise another BEmONC team member? While it is ideal to have specialists in SSV, our hospital has a limited number of specialists. Furthermore, SSV is not a teaching but, rather, a learning session. Peer review is an accepted mode of supportive supervision whereby both sides learn by discussing and reviewing materials together. Thus, SSV helps both supervisors and supervisees improve their knowledge and skills.

Periodic assessments of SSV supervisors are carried out by the BEmONC trainers with the support of the project. It will be ideal if these assessments are continued even after the end of the project.

b. How long does it take?

It usually takes about three hours or half a day per facility. When planning SSV, it is advised to schedule only one or two facilities per day.

c. Does SSV disturb the services at the facility?

Yes, it does, and unfortunately that is unavoidable. However, it is for the good of the services provided to the clients. It is advisable to explain the purpose of the activity to the clients at the beginning of the SSV to help them understand and solicit their cooperation.

We realized that some facilities ask clients not to come to the facility on the day of SSV. However, this is not advised as having clients will help by giving supervisors chances to observe actual practices.

d. Are supervisees cooperative?

Yes. However, there was some resistance among supervisees at the beginning of SSV. They felt that SSV disrupted the services and took a long time. Some attitudinal problems are not easy to solve, and unless the supervisees see some benefits of SSV, their attitude toward it will not change. Our experience shows that many supervisees have become familiar with SSV and have slowly begun to recognize the positive side. They are now more cooperative.

e. Does it not become a routine check?

Once SSV becomes a routine check, it will lose much of its "supportive" essence. This relates very much to the motivation and attitude of supervisors and is something we would like to avoid. To that end, make sure that the results are shared and discussed. Feedback should be given to the SSV teams so that they feel supported and that their work is not wasted.

It is also important to review tools as the situation changes. Current tools were developed based on the situation when SSV started. They have flexibility particularly for skills observation. In fact, if SSV works well, skills should improve. Once a technical gap is identified and improved as a result of SSV, the team can focus on other areas.

f. What are the benefits of SSV?

SSV has contributed many benefits to the health system and services and at the personal level. In the health system, it improved the function of the referral system. Although we still have a long way to go to make the referral system fully functional, SSV has helped to improve the relationship between the primary facilities and the hospital so that referrals are more readily accepted. We also believe that SSV has strengthened the ILHZs by more clearly defining their role in monitoring and supervision.

SSV aims to improve service quality through regular contact and feedback. We can see, for example, that partograph use has improved, and facilities are more prepared to receive cases with sterile delivery packs always ready. According to the responses given by the facility staff to questionnaires, their services are more consistent with DOH guidelines due to constant reminding through SSV.

At the personal level, some hospital supervisors mentioned that their knowledge and skills improved as they needed to review books and their own practices in order to supervise.

g. Who supplies the SSV checklists and BEmONC clinical forms?

In theory, the ILHZs should provide the forms through their CHTF. However, many ILHZs are in the process of establishing and functionalizing the fund. ILHZs with functional CHTFs are already utilizing their funds to reproduce forms. For others in the meantime, the PHO helps in the duplication.

h. How does the hospital cope with the SSV while they don't have enough personnel?

The duty schedule is adjusted to the SSV schedules and is given in advance to the Chief Nurse and Chief of Clinics/Senior Resident Physician so that there will be no disruption in hospital services. However, the shortage of personnel in the hospital remains a great challenge. The project supported the training of some additional people on SSV to provide a bigger pool of supervisors at each hospital.

i. We have no DNSs. Can we still do SSV?

Yes. The composition of SSV members should be organized based on the local setup. In Leyte, DNSs are available who have supervisory roles over the RHUs. However, if there is no DNS, then the BEmONC team alone or together with DOH representatives can conduct SSV.

j. Do we have to use the same tool as in Leyte and Ormoc?

No. The tools can be tailored to the local situation. DOH MNCHN modules for integrated monitoring are also available. What SSV has achieved in Leyte and Ormoc is the establishment of a system to support the conduct of regular SSV and monitoring through the ILHZ. The current SSV tools can be reviewed and revised according to DOH updated guidelines if facilities have achieved the service quality expected of them. It is necessary to develop and revise databases based on the tools.

k. Is SSV sustainable as it is currently carried out, even after the SMACHS project ends?

Yes, because the Project did not intentionally put resources toward actual SSV implementation by the ILHZ. The Project's input was limited to preparatory work, initial supply of tools, and training on SSV. The SSV so far has been conducted with whatever local resources are available and with some sacrifice by the SSV teams. Recognizing the need for motivation of the SSV members and sustainability of the SSV system, the PHO and ILHZs have set some measures to ensure that the SSV teams' efforts are recognized and some allowance is paid so that SSV members don't pay out of pocket.

l. Can a nurse supervise the doctors?

This depends on what the nurse will supervise. Obviously, for medical and technical aspects, it will not be appropriate. It is acceptable, however, for nurses to supervise in subjects for which nurses are trained as the leading personnel. A few doctors are not comfortable being supervised by nurses during SSV; however, as far as BEmONC services are concerned, nurses undergo the same training. Peer review is an accepted method of supervision. They should treat each other with respect.

m. Who supervises the SSV supervisors?

This is a very good question. Ideally, the Maternal and Neonatal Services of the hospital should be supervised by the combined group of regional hospital, DOH RO 8, and PHO. Currently, this has not been developed due to time constraints, and SSV is concentrated at the primary level. However, SSV teams have been assessed periodically by BEmONC trainers, DOH RO 8, and PHO/Ormoc CHD so that they maintain a higher level of BEmONC-related knowledge and skills.

SSV is conducted to ensure quality services to the families.

ANNEXES

Annex 1

1. Calendar of activities related to the introduction of SSV and the establishment of a MNCHN monitoring system

Timing		BEmONC related Training	ILHZ based SSV related activities	Monitoring system development
2010	Nov	BEmONC training of RHU/DHC staff (Project support for 27 teams, and DOH support for 3 teams)	Involving referral hospitals for post training monitoring was discussed with MNCHN coordinators of DOH RO 8, Leyte PHO and Ormoc Ormoc CHD.	Monitoring of MNCHN strategies was analyzed. Proposal for ILHZ based SSV was discussed at DOH RO 8/PHO.
2011	Jan – Feb	BEmONC training of hospital staff (DOH support for 9 teams)	Negotiated with DOH for the training of hospital teams for BEmONC.	
	May-Aug	Monitoring of BEmONC trainees by VSMMC trainers	The monitoring of BEmONC trainees indicated the need for the regular follow-up.	
	Aug	Hospital BEmONC teams were assessed on-site by the Project/DOH RO 8/PHO team.		Overall monitoring framework was agreed upon by stakeholders. Technical Working Group (TWG) on Monitoring was formed 1st TWG meeting took place.
	Aug		BEmONC clinical forms and SSV tools were developed and tested	
	Sept.		Orientation of RHU/DHC staff on BEmONC clinical forms and SSV. SSV training of hospital BEmONC and Ormoc Ormoc CHD teams	
	Oct		Started SSV targeting 20 facilities in Leyte province ad 5 DHC in Ormoc, which are the target of the Project	

2012	Jan – May 2012	118 Midwives at BHSs under target facilities were trained for 'Capacity Enhancement of Midwives for Maternal and Neonatal Care'	Each ILHZ continued SSV	2nd TWG meeting TWG meetings to discuss the implementation of SSV and its results. Measures to facilitate SSV implementation were discussed.
	Mar-April 2012	Assessment of BEmONC teams (RHU/DHC, Hospitals) 1		3rd TWG meeting
	May – Aug 2012 -	Follow-up of midwives		
	Aug.	Post Training Evaluation of Midwives by POGS (till Jan 2013)	Inclusion of the follow-up of midwives into SSV	4th TWG meeting
	Sep.		Review of BEmONC Clinical forms and SSV tools	5th TWG meeting
	Oct.		Orientation of BEmONC teams (RHU/DHC), and SSV teams on the revised tools SSV training for additional supervisors	6thTWG meeting to develop monitoring tool for linking SSV and MNCHN strategy monitoring
2013	Jan.	Leyte PHO trained the rest of 46 RHU staff on BEmONC with DOH support Ormoc CHD trained the remaining 1 DHC staff on BEmONC with DOH support		7thTWG meeting Training of PHO/ ILHZ coordinators/DNS/Ormoc CHD staff on monitoring tool Assignment of DOH RO 8 SSV point person
	April		Expansion of SSV to all facilities in Leyte and Ormoc	8thTWG meeting Database development for monitoring
	Sept.	Assessment of BEmONC teams (RHU/DHC, Hospitals) 2		
	Oct.		SSV manual write-up workshop	9thTWG meeting
	8 Nov.	Typhoon struck Leyte – SSV and other related activities suspended		
2014	May		Assessment of SSV	
	June		ILHZ coordinators/DNS meeting to re-establish SSV	
	July		SSV manual write-up	
	Sep.		SSV manual review and finalization	10th TWG meeting

Annex 2: BEmONC Clinical Recording Forms

1) BEMONC ASSESSMENT TOOL FOR ANTENATAL CARE
2) ADMISSION AND LABOUR RECORD
3) PARTOGRAPH
4) POSTPARTUM RECORD
5) BEMONC ASSESSMENT TOOL FOR POSTPARTUM CARE
6) BEMONC ASSESSMENT TOOL FOR NEWBORN CARE

BEmONC ASSESSMENT TOOL FOR ANTENATAL CARE

_____

Name of facility

FAMILY RECORD NO.: _____ PHILHEALTH NO.: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ ADDRESS: _____

CIVIL STATUS: _____ NAME OF HUSBAND: _____

OBS. HISTORY: G ___ P ___ (F ___ P ___ A ___ L ___) LMP: _____ EDC: _____ BLOOD TYPE: _____

	ASSESS (Instructions: put (✓) if yes, (X) if No, N/A for not applicable)	CLASSIFY			
1	**QUICK CHECK: (B2) / RAM (B3 TO B7)**	1st Visit	2nd Visit	3rd Visit	4th Visit
	● ASK, LOOK, LISTEN AND FEEL Date:	/ /	/ /	/ /	/ /
	● Is the woman being wheeled, carried or has any of the following?	☐	☐	☐	☐
	Note down in the column on the right, if any				
	• bleeding vaginally • severe headache				
	• convulsing • blurred vision				
	• looking very ill • in severe abdominal pain / epigastric pain				
	• unconscious				
	• severe pallor				
	• very difficult breathing and/or central cyanosis				
	• cold moist skin and/ or weak and fast pulse				
	• ruptured membranes				
	• in labor				
	• delivery is imminent				
	● CHECK VITAL SIGNS:				
	• Respiratory Rate (per minute)	_____	_____	_____	_____
	• Blood Pressure * If diastolic BP is >=90 mmHg, re-evaluate (see 5)	_____	_____	_____	_____
	• Pulse Rate (per minute)	_____	_____	_____	_____
	• Temperature	_____	_____	_____	_____
2	ASK CHECK RECORD (C2)				
	FIRST VISIT - PAST OBSTRETICAL HISTORY				
	• Ask LMP and calculate EDC (write down in the ID part, above)				
	• Ask obstetrical history (write them down in the ID part above)				
	• Age of Menarche:	_____			
	• Date of last delivery:	_____			
	• Prior caesarian section, (check for the scar)	☐			
	• Prior instrumental delivery	☐			
	• Prior third degree tear	☐			
	• Heavy bleeding during or after delivery	☐			
	• Convulsions	☐			
	• Stillbirth or death in the first day specify _____	☐			
	PAST MEDICAL CONDITION				
	● Ask for medical conditions (Diabetes, Hypertension, TB, Asthma, Heart conditions) Specify. If none, write down NONE.	_____			
3	**ALL VISITS (C2)**				
	• Age of gestation in weeks	_____	_____	_____	_____
	• Where do you plan to deliver (check Birth/Em.plan)	_____	_____	_____	_____
	• Any vaginal bleeding since last visit?	☐	☐	☐	☐
	• Is baby moving? (after 16 weeks)	☐	☐	☐	☐
	• Fundic height (cm)	_____	_____	_____	_____
	• Weight (kg)	_____	_____	_____	_____
	• Edema (-/+/++)	_____	_____	_____	_____
	• Do you have any concerns? Specify: If none, write down NONE.	_____	_____	_____	_____
4	**THIRD TRIMESTER (C2)**				
	* Multiple pregnancy?	☐	☐	☐	☐
	* Check for presentation	_____	_____	_____	_____
	* Fetal Heart Rate (beats per minute)	_____	_____	_____	_____
	* Transverse lie/breech?	☐	☐	☐	☐
	* Has she been counseled on family planning?	☐	☐	☐	☐
	If yes, please specify what method: _____	_____	_____	_____	_____

	ANTENATAL CARE ASSESS	CLASSIFY			
		1st Visit	2nd Visit	3rd Visit	4th Visit
5	**CHECK FOR PRE-ECLAMPSIA （C3)** ● ASK, CHECK RECORD (Refer to page 1 for Blood Pressure) ● LOOK, LISTEN, FEEL * If diastolic BP is >=90 mmHg, repeat after 1 hour rest * If diastolic BP is still >=90 mmHg, ask the woman if she has; - Severe headache/blurred vision/Epigastric pain * Check protein in urine(-/+/++)				
6	**CHECK FOR ANEMIA （C4)** ● ASK, CHECK RECORD ・ Hgb measured? (If so, write down the value) ・ Do you get tired easily? ・ Are you breathless (short of breath) during routine household work? ● LOOK, LISTEN, FEEL * Look for conjunctival and palmar pallor. Are they pale? * Is the RR more than 30/min?				
7	**DOES THE PATIENT HAVE ONE OF THE FOLLOWING** OBSERVED SIGNS OR VOLUNTEERED PROBLEMS? ・ No fetal movement (C7) ・ Ruptured membranes and no labor (C7) ・ Fever and/or burning in urination (C8) ・ Vaginal discharge (C9) ・ Coughing or difficulty in breathing (C11) ・ Taking Anti-TB Drugs (C11) ・ Smoking, alcohol or drug abuse or history of violence (C10) ・ Signs suggesting HIV infection (C6/C10) or syphilis (C5) ・ Current medical condition (DM, HPN, TB, Asthma, Cardiac condition) Specify: _____				
8	**PHISICAL EXAMINATION FINDING** ● Check for Nutrition, Skin. Head and Neck, Heart and Lungs, Breasts/ Nipples, Extremities, and write down any abnormal findings				
9	**OTHER LABORATORY FINDINGS**				
10	**ASSESS FOR OTHER PROBLEMS:** ・ For women with special needs (H1-H4)				
11	**INFORM AND COUNSEL ON HIV (G2-G8)** ・ Provide information on HIV and counsel on VCT (G2/G3) ・ If HIV positive, counsel on infant feeding choice (G7,G8)				
12	**PREVENTIVE MEASURE (C12)** * Tetanus Toxoid given (TT1 - TT5) - pls specify * No. of Iron/Folate tabs given * Oral health (Examination and prophylaxis, at least once)				
13	**ADVICE/COUNSELLING** ・ Self-care （C13) (M2) ・ Nutrition （C13) ・ Routine and follow-up visits (C17)(M2) ・ Advice on labour and danger signs (C15)(M9)(M2) ・ Breastfeeding (K2-K8) ・ Newborn screening (J12)				
14	**DEVELOP AND ATTACH BIRTH AND EMERGENCY PLAN （C14) (M3)**				

15	OVERALL ASSESSMENT	Management (Treatment/Advice)
1st		
2nd		
3rd		
4th		

16	**DATE OF NEXT VISIT' (AGREED UPON WITH THE WOMAN)**	/ /	/ /	/ /	/ /
17	**ASSESSMENT DONE BY: (write your name)**				

* Record relevant findings/management to the Mother and Child Book.

ADMISSION AND LABOUR RECORD NAME OF FACILIY: PHILHEALTH NO.:

USE THIS RECORD FOR MONITORING DURING LABOUR FAMILY RECORD NO.:

NAME: AGE: ADDRESS:

G: P: (F: P: A: L:) EDC: AOG: BLOOD TYPE: Hgb: RPR: HIV:

ADMISSION DATE ADMISSION TIME

TIME LABOUR STARTED (reported by women) TIME MEMBRANES RUPTURED

ENTRY EXAMINATION Fundic Height: Presentation: Lie: No.of fetus: Engagement:

INTERNAL EXAMINATION (IE) Ask any vaginal bleeding in late pregnancy ☐ Yes ☐ No **IF BLEEDING or HISTORY OF IT, DO NOT PERFORM IE**

Cervical Dilatation: _____ cm. Effacement: _____ Membranes: ☐ Ruptured ☐ Intact Presentation: _____ Station: _____

STAGE OF LABOUR ON ADMISSION NOT IN ACTIVE LABOUR ☐ ACTIVE LABOUR ☐

RECORD HERE IF NOT IN ACTIVE LABOUR

HOURS SINCE ARRIVAL	0	1	2	3	4	5	6	7	8	9	10	11	12
TIME													
HOURS SINCE RUPTURED MEMBRANES													
VAGINAL BLEEDING (0, +, ++)													
STRONG CONTRACTIONS IN 10 MINUTES													
FETAL HEART RATE (BEATS PER MINUTE)													
MATERNAL BODY TEMPERATURE													
PULSE (BEATS/MINUTE)													
BLOOD PRESSURE (SYSTOLIC/DIASTOL.)													
URINE VOIDED (Yes/No)													
CERVICAL DILATATION (CM)													
Treatment ( )													
Treatment ( )													

Referral (D4-D5)

Ruptured memb. & Temp.>38°C
Preterm
Pre-eclampsia
Severe anaemia
Obstructed labour
Vaginal bleeding
Sudden & severe abd. pain
HIV positive
Previous CS
Fetal distress
Other complication

PROBLEM	**TIME ONSET**	**TREATMENTS OTHER THAN NORMAL SUPPORTIVE CARE**

IF MOTHER REFERRED DURING LABOUR, RECORD TIME AND EXPLAIN

*Record relevant findings /Management to Mother and Child Book

PARTOGRAPH (USE THIS FORM FOR MONITORING ACTIVE LABOUR)

Name of Facility: _____

Name : _____ Address: _____ Family Record No.: _____ PhilHealth No.: _____

Date: _____

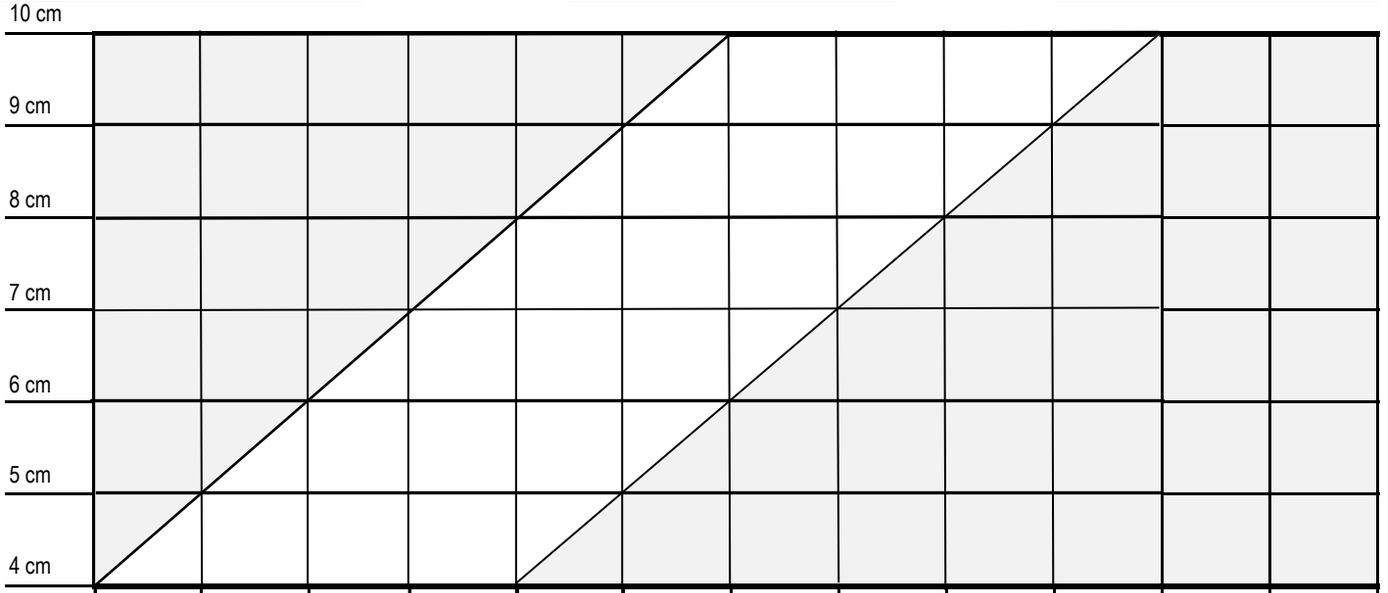
*** Start on the alert line**

*** Mark "X" for cervical dilatation**

Initial Examination. If NOT NORMAL, REFER.
Normal means cephalic, longitudinal, singleton and >37wks.

Presentation	
Lie	
Number of Fetus	
AOG	

*** Record time over the line corresponding to cervical dilatation**



FINDINGS	TIME											
Hours in active labour	1	2	3	4	5	6	7	8	9	10	11	12
Hours since ruptured membranes (Time of the rupture:)												
Rapid assessment **B3 - B7** (every 30 minutes)												
Vaginal bleeding (0/ +/ + +)												
Amniotic fluid I: Intact, C: clear M: meconium stained B: bloody												
Contractions in 10 minutes (every 30 minutes)												
Fetal heart rate (120-160/min is normal) (every 30 minutes in the 1st stage)												
Urine voided (Yes/No) (To check every 2 hours)												
Temperature (every 4 hours)												
Pulse (beats/minute) (every 4 hours if no problem)												
Blood pressure (systolic/diastolic) (every 4 hours if no problem)												
Cervical dilatation (cm) (every 4 hours unless indicated)												
Problem - onset/describe												
Management												

Birth date: _____ Time: _____ Livebirth ☐ Stillbirth: Fresh ☐ Macerated ☐ Oxytocin (Doses & Time given): _____

Delivery of Placenta (time): _____ Placenta & membrance complete ☐ Yes ☐ No Estimated blood loss: _____

Newborn: Sex: _____ Birth weight: _____ gm. Birth Length: _____ Head Circumference: _____ Chest Circumference: _____ Preterm: ☐ Yes ☐ No

Apgar Score: 1min: _____ 5mins: _____ Gest. Age: _____ Resuscitation Done: ☐ Yes ☐ No

*Record relevant findings /Management to Mother and Child Book

POSTPARTUM RECORD

NAME OF FACILITY: _____ PHILHEALTH NO.: _____

Name: **Address:** **Time of delivery:** **Type of Delivery:**

MONITORING AFTER BIRTH	EVERY 15 MIN FOR 1ST HOUR				2 HR	3 HR	4 HR	8 HR	12 HR	16 HR	20 HR	24 HR
DATE												
TIME												
MATERNAL: (N: Normal range)												
RAPID ASSESSMENT（Consciousness: Yes/No)												
BLEEDING (a pad soaked in <5mins)												
UTERUS HARD/ROUND? (Yes/No)												
BLOOD PRESSURE												
• Severe headache, blurred vision, etc (Yes/No)												
PULSE (N: (60-100/min) (note if weak or bounding)												
RESPIRATORY RATE (N: 12-20/min)												
TEMPERATURE												
URINE VOIDED (Yes/No)												
PERINEIUM (bleeding, swollen, pain)												
NEWBORN:												
RESPIRATORY RATE (N: 30-60/min)												
▪Sign of difficult breathing (grunting, chest in-drawing)												
HEART RATE (N: 100-120/min)												
WARMTH (Axillary Temperature: 36.5℃ - 37.4℃)												
NEW BORN ABNORMAL SIGNS (if any, note)												
FEEDING OBSERVED (well, difficult**)**												

PROBLEM - ASSESSMENT/MANAGEMENT	TIME	TREATMENT GIVEN
MOTHER		
NEWBORN		

IF REFERRED (MOTHER OR NEWBORN), RECORD TIME AND EXPLAIN:

IF DEATH (MOTHER OR NEWBORN), RECORD DATE, TIME AND CAUSE:

*Record relevant findings /Management to Mother and Child Book

ADVISE AND COUNSEL (D26)

MOTHER

- ☐ Postpartum care & hygiene
- ☐ Nutrition
- ☐ Birth spacing & family planning
- ☐ Breast feeding/care for breast/nipples
- ☐ Danger signs
- ☐ Follow-up visits / /

(Advise to come with the baby)

BABY

- ☐ Feeding
- ☐ Hygiene, cord care & warmth
- ☐ Special advice if low birth weight
- ☐ Danger signs
- ☐ Follow-up visits

PREVENTIVE MEASURES (D25)

FOR MOTHER

- ☐ Iron/folate _____ tabs
- ☐ Vitamin A
- ☐ Mebendazole
- ☐ Sulphadoxine-pyrimethamine
- ☐ Tetanus toxoid immunization
- ☐ RPR test results and treatment (C5/L5)
- ☐ ARV (G6)

FOR BABY

- ☐ Risk of bacterial infection & treatment
- ☐ BCG
- ☐ Hep-B
- ☐ Vit.K injection
- ☐ Tetracycline/Erythromycin eye ointment
- ☐ ARV (if applicable) (G6)

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BEmONC ASSESSMENT TOOL FOR POSTPARTUM CARE

_____

Name of Facility

FAMILY RECORD NO.: _____ PHILHEALTH NO.: _____

NAME: _____ AGE: _____ ADDRESS: _____

DELIVERY DATE : _____ DEL. PLACE: _____ TYPE OF DELIVERY: _____

	ASSESS (Instructions: put (✓) if yes, (X) if No)	CLASSIFY			
		On Discharge	1st Visit	2rd Visit	3rd Visit
		Date: / /	/ /	/ /	/ /
1	**QUICK CHECK (B2) / RAM (B3 TO B7)**				
	● ASK, LOOK, LISTEN and FEEL				
	● Is the women being wheeled, carried, or has any of the following?	☐	☐	☐	☐
	Note down in the column on the right, if any				
	• bleeding vaginally • severe pallor				
	• convulsing • in severe abdominal pain/epigastric pain				
	• looking very ill • blurred vision				
	• unconscious • severe headache				
	• very difficult breathing and/or cent. cyanosis				
	• cold moist skin and/or weak and fast pulse				
	● CHECK VITAL SIGNS				
	• Respiratory Rate	_____	_____	_____	_____
	• Blood Pressure	_____	_____	_____	_____
	• Pulse Rate	_____	_____	_____	_____
	• Temperature	_____	_____	_____	_____
2	**POSTPARTUM EXAMINATION OF THE MOTHER (E2)**				
	● ASK				
	• How are you feeling?(Does she seem to be unhappy?)	☐	☐	☐	☐
	• Do you have pus and/or pain in the perineum? Specify	☐ _____	☐ _____	☐ _____	☐ _____
	• Have you had fever or bleeding since delivery? Specify	☐ _____	☐ _____	☐ _____	☐ _____
	• Do you have any problem with passing urine? (dribbling, burning)	☐	☐	☐	☐
	• Have you decided on any contraception? Specify	☐ _____	☐ _____	☐ _____	☐ _____
	• Do you have any problem with breasts?	☐	☐	☐	☐
	• Do you have any other concerns? (cough, weight loss. etc) Specify if any	☐	☐	☐	☐
	● CHECK RECORD				
	* Any complications during delivery? Specify, if any	☐			
	* Receiving any treatments? Specify:_____	☐	☐	☐	☐
	* HIV status: Positive ?	☐			
	Is HIV Status Unknown?	☐			
	● LOOK, LISTEN, FEEL				
	• Feel Uterus. Is it hard and round?	☐	☐	☐	☐
	• Look at vulva and perineum for: tear/swelling/pus Specify	_____	_____	_____	_____
	• Look at pad for bleeding and lochia				
	*Does it smell?	☐	☐	☐	☐
	*Is it profuse?	☐	☐	☐	☐
	• Look for pallor, any pallor?	☐	☐	☐	☐
	• Is there any vaginal discharge 4 weeks after discharge?	☐	☐	☐	☐
3	**PLEASE PROCEED IF APPLICABLE, if any**				
	IF ELEVATED DIASTOLIC BLOOD PRESSURE (E3)				
	● ASK, CHECK RECORD				
	• History of pre-eclampsia/eclampsia in pregnancy/delivery/after delivery	☐	☐	☐	☐
	● LOOK, LISTEN, FEEL				
	• If diastolic blood pressure is >=90mmHg, repeat after a 1 hour rest	_____	_____	_____	_____
	IF PALLOR, CHECK FOR ANAEMIA (E4)				
	● ASK, CHECK RECORD				
	• Check record for bleeding in pregnancy, delivery or postpartum	☐	☐	☐	☐
	• Have you had heavy bleeding since delivery?	☐	☐	☐	☐
	• Do you tire easily?	☐	☐	☐	☐
	• Are you breathless (Short of breath) during routine housework?	☐	☐	☐	☐
	● LOOK, LISTEN, FEEL				
	• Measure haemoglobin if history of bleeding	_____	_____	_____	_____
	• Any conjunctival pallor?	☐ _____	☐ _____	☐ _____	☐ _____
	• Any palmar pallor? Is it severe pallor?/some pallor?, pls specify	☐ _____	☐ _____	☐ _____	☐ _____
	• Is RR more than 30/min?	☐	☐	☐	☐
	IF HEAVY VAGINAL BLEEDING (E6)				
	• More than 1 pad soaked in 5 minutes?	☐	☐	☐	☐
	IF FEVER or FOUL-SMELLING LOCHIA (E6)				
	● ASK Have you had: *foul-smelling lochia?	☐	☐	☐	☐
	*burning on urination?	☐	☐	☐	☐
	● LOOK, LISTEN, FEEL				
	• Feel lower abdomen and flanks for tenderness. Is it tender?	☐	☐	☐	☐
	• Any abnormal lochia?	☐	☐	☐	☐
	• Any stiff neck?	☐	☐	☐	☐
	• Any lethargy?	☐	☐	☐	☐

	POSTPARTUM CARE ASSESS	CLASSIFY			
3	**IF PROBLEM WITH PASSING URINE** ・Dribbling or leaking urine? (E7) ・Burning sensation (C8)				
	IF PUS OR PERINEAL PAIN (E7) ・Excessive swelling of vulva or perineum? ・Pus in perineum? ・Pain and swelling in perineum?				
	IF HIV STATUS IS POSITIVE (E5) ・Advise on additional care during postpartum ・Counsel on testing of the partner, use of condom and family planning ・Counsel on Infant feeding (G7,G8)				
	Guide for assessing some other postnatal problems (Write down classification in the box)				
	IF FEELING UNHAPPY OR CRYING EASILY (E7) ● ASK, CHECK RECORD ・How have you been feeling recently? ・Have you been able to enjoy the things you usually enjoy? ・Have you had your usual level of energy, or have you been feeling tired? ・Have you been able to concentrate (e.g., on newspaper articles or your favourite radio programmes)? ・Have you been in low spirits? ・How has your sleep been? Have you been sleeping well?				
	IF VAGINAL DISCHARGE 4 WEEKS AFTER DELIVERY (E8) ● ASK, CHECK RECORD ・Do you have itching at the vulva? ・Has your partner had a urinary problem? If partner is present in the clinic, ask the woman if she feels comfortable if you ask him similar questions. If YES, ask him if he has: ・Urethral discharge or pus ・Burning on passing urine ● LOOK, LISTEN, FEEL ・Separate the labia and look for abnormal vaginal discharge: *amount/colour/odour/smell ・If no discharge is seen, examine with a gloved finger and look at the discharge on the glove ・If partner could not be approached, explain importance of partner assessment and treatment to avoid reinfection.				
	IF COUGH OR BREATHING DIFFICULTY (E9) ● ASK, CHECK RECORD ・How long have you been coughing? ・How long have you had difficulty in breathing? ・Do you have chest pain? ・Do you have any blood in sputum? ・Do you smoke? ● LOOK, LISTEN, FEEL ・Any breathlessness? ・Any wheezing? ・Measure temperature (refer to RAM)				
	IF TAKING ANTI-TUBERCULOSIS DRUGS (E9) ・Are you taking anti-tuberculosis drugs? If YES, since when? ・Adivice (E9)				
	IF HIV STATUS UNKNOWN (E5) ● ASK, CHECK RECORD ・Have you ever been tested for HIV? ・If yes, do you know the result? (Explain to the woman that she has the right not to disclose the result) ・Has her partner been tested?				
	IF SIGNS SUGGESTING HIV INFECTION (E10) ● ASK, CHECK RECORD ・Have you lost weight? ・Do you have fever? How long (>1month)? ・Have you got diarrhoea (continuous or intermittent)? Assess if in a high risk group: (Occupational exposure/history of blood transfusion/ a commercial sex worker/Intravenous drug user?) ● LOOK, LISTEN, FEEL Visible wasting? Ulcers and white patches in the mouth (thrush)? Look at the skin: * Is there a rash? * Are there blisters along the ribs on one side of the body?				
4	**COUNSEL ON BREASTFEEDING (K2-K8)** **CHECK IF MOTHER HAS ANY PROBLEM WITH BREASTS (J9)** ・Examine the breast * Are nipples red and sore? * Are nipples cracked? (fissure) * Are the breasts engorged or swollen with pains? * Have fever? (Refer for the temperature in RAM)				

	OVERALL ASSESSMENT	Management (Treatment/Advice)
On Dis.		
1st		
2nd		
3rd		

NEXT CHECK-UP (1st visit- within 1 week; 2nd 2-3 wks; 3rd 4-6 weeks)	/ /	/ /	/ /	/ /
ASSESSMENT DONE BY: (write your name)				

*Record relevant findings /Management to Mother and Child Book

BEmONC ASSESSMENT TOOL FOR NEWBORN CARE

_____

Name of Facility

FAMILY RECORD NO.: _____ PHILHEALTH NO.: _____

NAME: _____ DOB: _____ BIRTH WEIGHT: _____ gm. DELIVERY TYPE: _____

MOTHER'S NAME: _____ ADDRESS: _____

	ASSESS (Instructions: put (✓) if yes, (X) if No)	CLASSIFY			
		On Discharge	1st Check-up	2nd Check-up	3rd Check-up
1	**OUICK CHECK (B2)** Date	/ /	/ /	/ /	/ /
	Does the baby have any of the following? Age	Days	Days	Days	Days
	• Very small, convulsions, difficult breathing, just born, or any maternal concern Specify:	☐	☐	☐	☐
	ASK/CHECK RECORD **(J2)**				
	Check maternal and newborn record of mother				
	• Preterm (less than 37 weeks)	☐			
	• Is the mother very ill or transferred	☐			
	• Any of the following? Breech delivery, difficult birth resuscitation at birth, had convulsions Specify:	☐			
	• Has baby passed meconium?	☐			
	• Has baby passed urine?	☐			
	• Asymmetrical movements of the limbs?	☐			
	CHECK				
	• Respiratory Rate (per minute) _____	_____	_____	_____	_____
	• Temperature (^{0} C) _____	_____	_____	_____	_____
	• Body weight (in grams) _____	_____	_____	_____	_____
2	**IS THERE PRESENCE OF DANGER SIGNS? (J7)**				
	Any of the following signs:				
	▪ Fast breathing (more than 60 breaths per minute).	☐	☐	☐	☐
	▪ Slow breathing (less than 30 breaths per minute).	☐	☐	☐	☐
	▪ Severe chest in-drawing	☐	☐	☐	☐
	▪ Grunting	☐	☐	☐	☐
	▪ Cyanosis of lips and mucus membranes	☐	☐	☐	☐
	▪ Apnea (not breathing)	☐	☐	☐	☐
	▪ Fever (temperature >38° C)	☐	☐	☐	☐
	▪ Temperature <36.4° C or not rising after rewarming	☐	☐	☐	☐
	▪ Convulsions	☐	☐	☐	☐
	▪ Floppy or stiff	☐	☐	☐	☐
	▪ Umbilicus draining pus or umbilical redness extending to skin	☐	☐	☐	☐
	▪ >10 skin pustules or bullae, or swelling, redness, hardness of skin	_____	_____	_____	_____
	▪ Bleeding from stump or cut	☐	☐	☐	☐
	▪ Pallor	☐	☐	☐	☐
3	**IF PRETERM, BIRTH WEIGHT <2500G or twin (J3)**				
	ASK, CHECK RECORD				
	▪ Birth weight o <1500g	☐			
	o 1500g to 2500g	☐			
	▪ Preterm o <32 weeks	☐			
	o 33 to 36 weeks	☐			
	▪ Twin:	☐			
	LOOK, LISTEN, FEEL				
	* If it is a repeat visit, assess weight gain. Is it adequate?	☐	☐	☐	☐
4	**CHECK FOR SPECIAL TREATMENT NEEDS (J5)**				
	ASK, CHECK RECORD				
	▪ Has the mother had fever within 2 days of delivery? If so,	☐			
	o Mother had Fever >38° C?	☐			
	o Infection treated with antibiotics?	☐			
	▪ Membranes ruptured >18 hours before delivery?	☐			
	▪ Mother tested RPR positive? Write N/A if not done	☐			
	▪ Mother tested HIV+?	☐			
	o Has she received infant feeding counseling?	☐			
	▪ Is the mother on TB treatment which began <2 months ago?	☐			

	NEWBORN CARE: ASSESS	CLASSIFY			
		On Discharge	1st Check-up	2nd Check-up	3rd Check-up
5	**ASSESS BREASTFEEDING (J4)**				
	ASK, CHECK RECORD				
	Ask the mother				
	▪ Is the breastfeeding going well?	☐	☐	☐	☐
	▪ Has your baby fed in the previous hour?	☐	☐	☐	☐
	▪ Is there any difficulty?	☐	☐	☐	☐
	▪ Is your baby satisfied with the feed?	☐	☐	☐	☐
	▪ Have you fed your baby any other foods or drinks?	☐	☐	☐	☐
	▪ Is there any problem with breasts?	☐	☐	☐	☐
	▪ Do you have any concerns? Specify:				
	If baby is more than 1 day old:				
	How many times has your baby fed in 24 hours?				
	LOOK, LISTEN, FEEL (Observe a breastfeed)				
	If the baby has not fed in the previous hour, ask the mother to put the baby on her breasts and observe breast feeding for about 5 minutes				
	- Is the baby able to attach correctly?	☐	☐	☐	☐
	- Is the baby well positioned?	☐	☐	☐	☐
	- Is the baby suckling effectively?	☐	☐	☐	☐
	If mother has fed in the last hour, ask her to tell you when her baby is willing to feed again.				
6	**LOOK FOR SIGNS OF JAUNDICE AND LOCAL INFECTION (J6)**				
	ASK, CHECK, RECORD				
	▪·What has been applied to the umbilicus?				
	LOOK, LISTEN, FEEL				
	▪ Look at the skin,				
	* If baby is less than 24 hours old, look at the skin on the face, Is it yellow?	☐			
	* If baby is >=24 hours old, look at palms and soles. Is it yellow?	☐	☐	☐	☐
	▪ Look at the eyes. Are they swollen and draining pus?	☐	☐	☐	☐
	▪ Look at the skin, especially around the neck, armpits, inguinal area:				
	- Are there skin pustules?	☐	☐	☐	☐
	- Is there swelling, hardness or large bullae?	☐	☐	☐	☐
	▪ Look at the umbilicus:				
	- Is it red?	☐	☐	☐	☐
	- Draining pus?	☐	☐	☐	☐
	- Does redness extend to the skin?	☐	☐	☐	☐
7	**IS THERE ANY SWELLING, BRUISES, OR MALFORMATION?** If YES, refer to J8	☐	☐	☐	☐
8	**ASSESS OTHER PROBLEM: Ask mother: any concern?** Specify. If none, write down NONE	☐	☐	☐	☐
9	**ADVICE AND COUNSEL**				
	▪ Care of newborn baby (J10, M6)	☐	☐	☐	☐
	▪ Exclusive breastfeeding (K2-K8, M7)	☐	☐	☐	☐
	▪ Hygiene, cord care and warmth (K9, K10)	☐	☐	☐	☐
	▪ Special advice if low birth weight (J11)	☐	☐	☐	☐
	▪ Danger signs (M6)	☐	☐	☐	☐
	▪ Newborn screening (J12)	☐	☐	☐	☐

10	**OVERALL ASSESSMENT**	**MANAGEMENT (TREATMENT/ADVICE)**
On Dis.		
1st		
2nd		
3rd		

NEXT CHECK-UP (1st visit- within 1 week; 2nd 2-3 wks; 3rd 4-6 wks)	/ /	/ /	/ /	/ /
Assessment done by (name of health worker):				

*Record relevant findings /Management to Mother and Child Book

* Use this form to assess newborn at birth (after 90 min,) for discharge; and during the first week of life (routine & sick newborn visits)

Annex 3: Supportive Supervision Tools

Checklist 1: Resources
Checklist 2: Records Review
Checklist 3: Knowledge and Application
Checklist 4: Clients satisfaction and Mother and Child Book
Checklist 5: Referral Audit
Checklist 6: CHT Activities
Feedback Sheet
Action Plan

Centre for Health Development - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)
Supportive Supervision at RHU/DHC - Procedures

1. What to take for the supportive supervision

1) Last supervisions summary and Action plan
2) Referral records of the last month
3) All check lists
4) Stationary including some carbon paper
5) BEmONC manual

2. When and who to go

1) Make the plan with the COH to make monthly visit
2) Inform the facility of your visit
3) Plan your work amongst the team members

- Person who does the check list 1 needs to go round observing items on the check list and interview
- Person who does the check list 2 needs to get records
- Person who does the check list 3 needs to ask the BEmONC team to be present
- Person who does the check list 4 needs to talk to the clients discreetly
- Person who does the check list 5 needs to talk with the MHO/DHO

Actual division of responsibility can change depending on how many are there
Suggested division of work

	Person 1	Person 2	Person 3	Person 4
4 people	Checklist 1, 4 & 5	Check list 2	Check list 3	Check list 6
3 People	Checklist 1 , 4 & 5	Check list 2	Check list 3, 6	
2 people	Check list 1, 2, 4 &	Check list 3, 4,6		

3. On the site

1) Before you arrive, confirm who does what in the site
2) On the site, introduce yourselves and explain what you are going to do
3) Explain to the clients that it may disrupt the services
4) All supervisors will observe the labor, delivery and postnatal room
5) If there are clients, observe actual application of skills and knowledge.
6) Carry on with checklist. Fill in the assessment part whrn done.
7) When each person is done, all supervisors to sit together then summarize their findings using the feedback sheet. Compare with the last supervision results.
8) Prepare feedback sheet
9) Call all staff who are not attending the client and give feed back
10) Stress positive aspects. Congratulate of they have improved as their action plan.
11) Discuss whether the findings have been new or the same problems remain as before
12) Discuss and agree how to improve the situation (make an action plan. Prepare one for the hospital, if necessary)
13) Decide on the next supervision date
14) At the end, thank them for their time

Try to minimize the disturbance to their work

Centre for Health Development - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Check list 1: Resources

Facility:			Date:						
Areas		What to observe	Yes	No	Remarks				
1. Human resources	1	There is a complete BEmONC team?							
		How many remain of BEmONC trainees							
	2	Midwives trained: Are they all still in service			Number trained ( )				
		How many remain of trained midwives?							
	3	An ambulance driver available for 24 hours							
	4	The person assigned for cleaning is on duty today?							
2. Facility and Hygiene		Check for each room for cleanliness and privacy	Labor Rm		Delivery Rm		Postnatal Rm		
			Yes	No	Yes	No	Yes	No	
	1	Rooms and equipment are clean, including lavatory and the area under the cushion of delivery table.							
	2	There are means to protect client's privacy							
	3	There is an evidence that the staff are practicing hand-washing always (water, soap, clean towels, paper towel etc)							
	4	The facility has adequate water-supply							
	5	All instruments are autoclaved or sterilized? (no soaking)							
		If not using autoclave or sterilizer, how is it done?							
	6	Ask what is the recommended process of sterilization. (Decontamination, wash, dry, wrap individually and sterilize for adequate duration) Do they follow it?							
	7	Sharps are disposed as per guideline?							
	8	There is a placental pit for the disposal of the placenta							
	9	A wall thermometer is available in the Delivery Room.							
3. Readiness for receiving cases/ for emergency	1	BEmONC Manual is readily available							
	2	There are sterilized delivery packs ready for use (at least 2)							
	3	Oxytocin and emergency medicines are available. (MgSO4, Calcium Gluconate, hydralazine, ergometrine)							
	4	Syringes and needles (in various sizes) are available							
	5	IV fluids and tubing, cannula are ready for use							
	6	Drugs and supplies are organized in such a way that it is easy to locate them							
	7	Oxygen is ready for use							
	8	Room is ready for newborn resuscitation (ambubag, designated place, means for keeping the baby warm)							
	9	There is a functioning ambulance/ means of transport							
	10	There are means to communicate (telephone, radio) with referral hospitals and health offices							
	11	Telephone directory of emergency contacts is clearly placed and everyone knows it. (hotline number, the number of MHO/DHO and referral hospitals, ambulance driver)							
4. Logistics and Supplies	1	Equipment required for the BEmONC services are available and functional (see the list and RHU/DHC's inventory)?							
	2	There are adequate drugs and supplies (see the list and RHU/DHC's inventory)							
	3	Recording forms are available. (blank ones for ANC, Labor, Partograph, PNC, Newborn Care, Referral)							
5. Service delivery and performanc e	1	24 hours delivery services is in place including weekend (There is a roster of midwives)							
	2	How many deliveries took place last month? (Check with delivery logbook)							
	3	There is a functioning delivery tracking system							
		If not functioning, ask why?							
	4	How many deliveries are expected this month?							

Areas		What to observe	Yes	No	Remarks
6. MNDR	1	There is updated Maternal and Neonatal/Infant death logbook			
	2	Number of maternal deaths this year since January			(in the area covered by the facility)
	3	How many of above were reviewed?			
	4	Number of newborn deaths this year since January			(in the area covered by the facility)
	5	How many of above were reviewed?			
	6	Number of newborn deaths this year since January			(in the area covered by the facility)
	7	How many of above were reviewed?			
7. LGU/ Community support	1	Blood donors list is available			
		LGU passed following resolution/ordinance.			
	2	1) Facility based deliveries			
	3	2) User-fees			
	4	3) Incentives for CHT			
		If passed, are they implemented?			
	5	1) Facility based deliveries			
	6	2) User-fees			
	7	3) Incentives for CHT			
8, PhilHealth	1	This facility is currently accredited for MCP			
	2	This facility is currently accredited for Newborn screening			
	3	The facility receives the reimbursement regularly from PhilHealth			
	4	if so, when was the last reimbursement received?	When:		

Assessment: (Count the number of 'yes' answers and put ✓in the corresponding box)

Area		V.Poor		Poor		Good		V.Good	
1	Human resources adequate and trained	0-1		2		3		4	
1.1	How many remain of those BEmONC trained (Number trained:)								
1.2	How many remain of trained midwives (Number trained:)								
2	Facility in good condition, organized and clean	0-3		4-7		8-11		12-13	
3	Readiness for receiving cases/ for emergency	0-2		3-6		7-9		10-11	
4	LGU's commitment for drugs/supplies and equipment maintenance	0		1		2		3	
5	Delivery service provided and functionality of tracking system	0-1						2	
6.1	MDR being conducted (% of reviewed/deaths)								
6.2	NDR being conducted (% reviewed/deaths)								
7	Availability and implementation of Resolutions/Ordinances on FBD, user's fees and incentives for CHT	0-2		3-4		5-6		7	
8	Philhealth accreditation for MCP/Newborn screening (MCP+) and regular reimbursement	0		1		2		3	

Things to improve (List those items which had 'No' answer)

Note: If the BEmONC team is not complete, it should be reported to PHO via SSV report

Supervisor:

Centre for Health Development - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Check list 2: Records review

Facility:	Date:

* Take three records each for each record, preferably written by different persons			Case 1		Case 2		Case 3		**All**
Area		Items	Yes	No	Yes	No	Yes	No	**Qty. Yes**
1. Antenatal	1	BEmONC format for Antenatal Care is used.							
	2	It is filled completely including personal data following rules? (yes ☑ no☒, values, specific information)							
	3	EDC is correctly calculated							
	4	AOG is correctly calculated							
	5	Hgb is checked and recorded							
	6	Blood type is checked and recorded							
	7	Preventive measures are provided appropriately (TT, Iron, Oral health)							
	8	Mebendazole given once in second or third trimester							
	9	Any abnormal findings are classified and recorded in corresponding section (If all filled up and no abnormal findings, mark 'yes')							
	10	Overall assessment corresponds to the information/classification in each section?							
	11	Management based on the overall assessment is appropriate (always refer to the BEmONC manual for confirmation)							
	12	Women were given appropriate dates for the next visit depending on their gestation?							
	13	The woman came back on or around due dates for check-up.							
	14	Birth/Emergency plan attached to the antenatal record							
	15	All items of the birth an emergency plan is filled							
		Count how many items has all 'Yes'							
2. Labor-Record Partograph	1	BEmONC format is used for all admission							
	2	Examination on admission is carried out and recorded							
	3	The table part of the labor record is used only for latent phase of the labor.							
	4	All required observations are recorded for women in inactive labor							
	5	If treatment (IV or antibiotics, etc) is given, is the indication written down? (If not given, N/A)							
	6	BEmONC partograph is used for active labor.							
	7	The first IE (dilatation) charted on the alert line, time on the line and observations recorded in the corresponding place.							
	8	The cervical dilatation is marked by 'X'.							
	9	IE was done every 4 hours unless indicated							
	10	Time of the rupture of membranes is noted							
	11	RAM is carried out every 30 minutes							
	12	Vaginal bleeding is checked and recorded							
	13	Color and smell of amniotic fluidis are checked							
	14	Contractions (in 10 minutes) are checked and recorded							
	15	FHR is checked and recorded every 30 minutes							
	16	Urine voided' is checked (checked every 2 hours)							
	17	Maternal temperature and pulse taken and recorded every 4 hours.							
	18	Maternal BP is taken and recorded hourly							
	19	Cervical dilatation is recorded, which corresponds to the graph.							
	20	The time of delivery of placenta is recorded							
	21	Time of Oxytocin administration is recorded							
	22	Data are consistent							
	23	Evidence of appropriate judgment and management done, based on observations (i.e. more frequent obs, referral etc.)							
	24	Delivery took place before crossing action line							
		Count how many items has all 'Yes'							
3. Immediate postpartum and	1	BEmONC form is used							
	2	All observations are recorded up to 12 hours minimum. This includes Rapid Assessment and Management (RAM)							

Area		Items	Yes	No	Yes	No	Yes	No	Qty. Yes
(3. cont.)	3	If antibiotics are given to mother or baby, their indications written down? (If not given, write 'N/A'.)							
	4	Vit. A given							
	5	Iron given							
	6	Advice and Counsel' are given							
	7	Next follow-up date given within 7 days to the mother.							
		Count how many items has all 'Yes'							
4. Postpartum Care	1	BEmONC postpartum record is used and information on the discharge is recorded							
	2	It is filled completely including personal data following rules? (yes ☑ no☒, values, specific information)							
	3	Any abnormal findings are classified and recorded in corresponding section (If all filled up and no abnormal findings, mark 'yes')							
	4	Preventive measures are provided (Iron and TT - if necessary)							
	5	Overall assessment corresponds to the information/ classification in each section?							
	6	Management based on the diagnosis is appropriate (always refer to the BEmONC manual for confirmation)							
	7	Mother was given appropriate dates for the next visit depending on the recommended schedule.							
	8	Mother came back on or around due dates for check-up.							
		Count how many items has all 'Yes'							
5. Newborn care	1	BEmONC newborn record is used							
	2	It is filled completely including personal data following rules? (yes ☑ no☒, values, specific information)							
	3	Any abnormal findings are classified and recorded in corresponding section (If all filled up and no abnormal findings, mark 'yes')							
	4	Overall assessment corresponds to the information/classification in each section.							
	5	Management based on the diagnosis is appropriate (always refer to the BEmONC manual for confirmation)							
	6	Mother was given appropriate dates for the next visit depending on the recommended schedule.							
	7	Mother brought her baby on or around due dates for check-up.							
		Count how many items has all 'Yes'							
6. Referral	1	Standardized form is used			Remarks:				
	2	Out-going referral and feedbacks are recorded in the logbook			Remarks:				
7. Delivery Logbook	1	Standardized delivery logbook is used			Remarks:				
	2	Delivery logbook filled correctly			Remarks:				

t

		Number of items with all 'yes' answers: Mark ✓ corresponding number for each record	V.Poor		Poor		Good		V.Good	
Process	1	ANC	0-3		4-8		9-12		13-15	
	2	Labor and Partograph	0-6		7-12		13-19		20-24	
	3	Immediate Postpartum care	0-2		3-4		5-6		7	
	4	Postpartum care	0-2		3-4		5-6		7-8	
	5	Newborn care	0-2		3-4		5-6		7	

Summarize the points for improvement (List those items which had no or only 1'Yes' amongst all records reviewed)		
	1	ANC: If there is a problem with EDC, AOG calculations, it should be taught during the feedback session
	2	Labor and Partograph: Particularly point out if the labor took place after action line.
	3	Immediate Postpartum
	4	Postpartum care
	5	Newborn care

Supervisor: _____

Centre for Health Development - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Check list 3: Knowledge and Application

Facility:	Date:

1. Practices (Observe skills. If no client, you could ask to simulate the situation)

Use DOH tools for observation as applicable

	Practices you observed	Who did it	All correct (Yes/No)	Areas to improve
1				
2				
3				
4				

2. Application of BEmONC signal functions and other skills learnt in the BEmONC Training. (In the last quarter)

In the last quarter, have you applied the following skills? (If no, select reason from the list below. Multiple answers possible)		Physician			Nurse			Midwife (BEmONC)			Is anybody doing? (Y/N)
		Yes	No	If no, Reason	Yes	No	If no, Reason	Yes	No	If no, Reason	
1)	Parenteral administration of Oxytocin										
2)	Parenteral administration of antibiotics										
3)	MgSO4 administration										
4)	Imminent breech delivery										
5)	Manual removal of retained products (incomplete abortion)										
6)	Manual removal of retained placenta										
7)	Dexamethasone for preterm labor										
8)	Newborn resuscitation										
9)	IV insertion										
10)	Suturing										

Midwives trained for Capacity enhancement

In the last quarter, have you applied the following skills? (If no, select reason from the list below. Multiple answers possible)		RHM 1			RHM 2			RHM 3			Is anybody doing? (Y/N)
		Yes	No	If no, Reason	Yes	No	If no, Reason	Yes	No	If no, Reason	
1)	Correct IE procedures										
2)	Active management of the 3rd labor										
3)	Essential Newborn care										
4)	IV insertion										
5)	Suturing										
6)	Newborn resuscitation										

Reasons for not performing (Multiple answers possible. write the corresponding letters)

If 'No case' is an answer, please ask if they could perform them should a case arise

a, Not trained
b. Afraid of doing it/ not confident
c. Forgot as never practiced
d. No cases
e. No medicine
f. No supply
g. not allowed
h. Others

3. Knowledge

・Select one or two topics depending on observed or felt needs and discuss with the staff, such as recent emergency case.

・All (1-4) should be covered within a year.

・Use the discussion guide for the topic, attached to this form. Utilize the BEmONC manual as well.

Topics

1) Care of woman in labor/delivery, Use of partograph (Use actual partograph being recorded)
2) Active management of the third stage of labor, and the management of postpartum haemorrhage
3) Essential newborn care and newborn resuscitation
4) Pre-eclampsia, Eclampsia and its management
5) Any others

	Topic chosen	Areas to improve, if any.
1		
2		

Assessment Rate qualitatively based on the guide/BEmONC Manual

1	Actual Practices (Refer to 1)	V.Poor ( ), Poor( ), Good ( ), V.Good ( )				
2	BEmONC signal functions and enhanced skills for midwives		How many are done		How many are not done at all	
		BEmONC Team	of 10		of 10	
		Midwives trained	of 6		of 6	
		Whar are not performed and reasons for not being performed.				
3	Knowledge (Refer to 3)	V.Poor ( ), Poor( ), Good ( ), V.Good ( )				

Supervisor: _____

Supportive Supervision - Discussion guide

Use BEmONC manual as reference

1) Care of woman in labor/delivery, Use of partograph (Use actual partograph being recorded)

A *How do you know when a pregnant woman is in labor?*

- Regular uterine contractions
- Dilatation of cervix
- Discharge of blood and mucus
- Breaking of waters(ruptured membranes)

B *What would consist of good care of women in labor*

- Encourage the woman to drink and eat
- Encourage the woman to move about
- Encourage the woman to void urine, Why?
- Give emotional support and maintain good communication
- Woman allowed to have a companion of her choice
- Check signs of progress of labor and record them
- Record vital signs at determined intervals
- During delivery, woman's back propped up or left lateral position, Never leave the women lying flat. Why?

C *Partograph*

- Was it used only in active labor (the cervical dilatation is >=4 cm? & regular strong contractions 3 in 10 min.)
- Was the first IE (dilatation) charted on the alert line and observations recorded in the corresponding place?
- Was the cervical dilatation marked by 'X' and connected
- Was IE done every 4 hours unless indicated? What may be the indication for unscheduled IE?
- FHR checked and recorded every hourly. What is the normal range? What to do if abnormal?
- Maternal temperature and pulse taken and recorded every 4 hours unless indicated otherwise.
- Maternal BP taken and recorded hourly? What is normal range? If abnormal, what do you do?
- All other observation recorded
- Delivery/Birth summary noted
- Judgment on the progress of labor, and management

2) Active management of the third stage of labor, and the management of postpartum haemorrhage

A *Active management of the third stage of labor*

- Give oxytocin(10 IU, im) after the birth of the baby(but excluding another baby is in the uterus)
- Wait for the signs of separation of the placenta (uterus contracted, gash of blood, lengthening of the cord)
- Apply controlled cord traction and deliver the placenta and membranes.
- Describe how to do CCT (gentle and steady traction of the cord while applying counter traction above the symphysis pubis). Wait if the placenta does not descend, then repeat when the uterus contracts again.
- Check the placenta and membranes for completeness Why?
- Ensure the uterus is contracted and observe vaginal bleeding
- Check for laceration and suture
- Check for vital signs and record
- Know the danger signs (shock, bleeding, convulsions, headaches etc.)
- Encourage to void urine Why?
- Never leave mother and baby alone
- Attend to women's comfort

B *What do you do if the postnatal woman develops heavy bleeding? （C4)*

- Massage the fundus
- Insert an IV line, Give oxytocin (20 Units in IV fluid, at 60 drops per minutes) Maintenance dose 20 units, 30
- Empty the bladder, Catheterize if necessary
- Take blood for cross-matching
- Examine woman for lacerations and repair if not 3rd degree tear.
- Manually remove the retained placenta, if this is suspected
- Monitor vital signs
- Refer if necessary

3) Essential newborn care and newborn resuscitation

A *What immediate care do you give to the newborn (in order)*

- The baby is placed on the abdomen of the mother after the birth
- Immediate drying of the baby
- Clean the face and mouth but no suction
- Skin to skin contact and keep the baby warm
- Check for breathing (simultaneously with other action)
- Check for the color of the baby (simultaneously with other action)
- Cord is clumped when the pulsation stops
- No separation from the mother and initiate breast feeding
- Examination of Newborn and Standard Prophylaxis
- Check axillary temperature of the baby (know the normal temperature?)
- Give the vit.K i,m. (know the dose?)
- Give Hep B vaccination
- Give BCG vaccination
- Check weight
- Examine the baby head to toe and record

B *What do you do if the baby weighs less than 2.5 kg, what special care do you provide?*

- Make sure the baby is warm (Skin to skin/kangaroo care)
- Provide extra support for the mother to establish breast feeding
- Monitor ability of the baby to breastfeed
- Monitor baby for the first 24 hours
- Ensure infection prevention

C *What are the signs of sick newborn baby?*

- Less movement (poor muscle tone)
- Poor or no breastfeeding
- Hypothermia or hyperthermia
- Restlessness or irritability
- Difficulty breathing or fast breathing, chest in-drawing
- Deep jaundice
- Severe abdominal infection

D *Newborn resuscitation*

- Describe how to do it, and assess if it is correct (it should be done in the following steps)
- Explain to the mother and other significant persons
- keep baby warm
- clear airways, suction mouth then nose
- Positioning of the baby (face-up, the neck slightly extended)
- How to place the mask of ambubag
- How many times/ minute to ventilate/ squeeze the bag (40 times/min.)
- Pause and determine if the baby is breathing spontaneously
- If no breathing or gasping at all after 20 minutes of ventilation, stop ventilation, Explain to the parents
- Record all

4) Pre-eclampsia, Eclampsia and its management

A *Signs and symptoms of Pre-Eclampsia/Eclampsia (C3)*

- Hypertension What is the normal range?
- Severe headache
- Blurred vision
- Epigastric pain
- Protein in urine

B *What is the definition ?*

- Severe pre eclampsia (C3)
- Pre eclampsia

C *How do you manage severe eclampsia (C3)*

- Give MgSo4, what is the dose (B13)
- Give hydralazine (B14) What is the dose? (B14)
- Refer urgently to hospital

D *How do you care if the woman is convulsing*

- Protect woman from fall and injury
- Manage airway (B9)
- After convulsions, help woman onto her left side
- Insert IV line and give fluids very slowly
- Give MgSO4 (B14)
- If diastric BP >110mmhg, give hydralazine
- Refer urgently to hospital

For observation of skills, use the DOH monitoring tools as applicable.

Centre for Health Development - Eastern Visayas

Family Health Cluster

Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Check list 4: Client satisfaction and Mother and Child Book

Facility:		Date:					
		Client 1			Client 2		
	Client Satisfaction	Yes	No	Not sure	Yes	No	Not sure
1	I received the care or service I came for.						
2	I was greeted and treated well by all the staff						
3	The service was prompt. I did not wait that long before someone attended to me						
4	The facility is clean and orderly						
5	The health staff respected my privacy						
6	The health care provider explained very well my condition and I understood well.						
7	The advice and instructions given me were completely clear and I understood well.						
8	I am sure that all information concerning myself is treated as confidential						
9	I felt free to ask questions or express my fear.						
10	I have confidence in the staff's ability to care for me.						
	Care during labor	Yes	No	Not sure	Yes	No	Not sure
1	Did you have a baby here? If so, please answer the following.						
2	During my delivery, my privacy was protected						
3	During my labor, I was encouraged to drink and eat.						
4	During my labor, I was encouraged to move about.						
5	I want to come back again for the next one						
	Mother and Child Book /Home based maternal record	Yes	No		Yes	No	
1	Do you have your Mother and Child Book or HBMR with you now? If she says no, go to Q. 5						
2	(Ask her to show it) Recording is satisfactory						
3	Has a CHT member discussed with her the contents of MC Book?						
4	Birth and emergency plan filled up completely (in the MC Book or attached to HBMR)						
5	If the answer is no, ask why she has no MCB or HBMR with her today. Write down the reason. (the corresponding letter) Reasons (Write down the letter) a. not given b. was not aware to bring c. forgotten d. lost e. other (specify)						

How can the staff of this health center improve their services? (Client's opinion) Refer to where she answered 'not sure' or 'no'.

Client 1:

Client 2:

Assessment: Count the number of Yes among two clients. For Q 2, if non of them had their babies in this facility, no need to fill.

Use this if only ONE client was interviewed		V.Poor		Poor		Good		V.Good	
1	Client's satisfaction	0-3		3-6		7-8		9-10	
2	Care during labor (If applicable for both clients, use here)	0-1		2-3		4		5	
3	MC Book or HBMR and Birth plan (Q.1-4 only)	0-1		2		3		4	
Use this when Two clients were interviewed									
1	Client's satisfaction	0-5		6-11		12-17		18-20	
2	Care during labor (If applicable for both clients, use here)	0-2		4-6		7-8		9-10	
3	MC Book or HBMR and Birth plan (Q.1-4 only)	0-2		3-5		6-7		8	

Recommendations

Supervisor:

Centre for Health Development - Eastern Visayas

Family Health Cluster

Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Check list 5: Referral Audit

Facility:	Date:

* The hospital supervisory teams to bring their records of referral
* Have the referral logbook of the facility

Write down figures. If there is no data, write down 'NO DATA'.

1 How many cases were referred to the hospital last month according to the record of the RHU/DHC?

a. _____

2 How many of them were received actually in the hospital? (Check with acknowledgement slips)

b. _____

3 Proportion of those who reached a hospital amongst referred cases

b/a _____ %

4 How many of cases among those received by the hospital were referred back to the RHU?

c. _____

5 Calculate the percentage

c/b _____ %

6 What happened to the cases referred?

* Select 3 cases randomly amongst those received feedback from hospital, to examine the following.

	Case 1	Case 2	Case 3
1) Reasons for referral			
2) Transport(means and accompany)			
3) Management before sending			
4) Condition on arrival at hospital			
5) What was done in hospital			
6) Outcome and Final diagnosis			
7) Referral justified. (Check partograph if labor case)			
8) Referral not justified. Why?			
9)	Number of justified referral cases/3 (Refer to (7)		%

Assessment: Mark appropriate place, Write down the comments under each item.

	No data	V.Poor 0-29%	Poor 30-59%	Good 60-89%	V.Good 90-100%
Referred cases reached to the hospital (Refer to 3)					
Two-ways referral system is functioning (Refer to 5)					
Referral were justified (Refer to 6 -,9))					
Areas to improve;					

Supervisor: _____

Centre for Health Development - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Check list 6: CHT Activities

Facility:		Date:		
No.	Question	Y	N	Remark
1	Availability of CHT inventory (updated) at RHU			
2	Availability of consolidated CHT report at RHU/DHC level for the last three months *please collect a copy of CHT monthly report			
3	Record of a monthly CHT meeting at RHU/DHC level for the last three months			
4	Record of a monthly CHT meetings at BHS level filed at the RHU/DHC			
A. Total				
CHT Monthly Report: Data consistency, identified problems and the actions taken *(use the latest CHT monthly repo*				
Accuracy of the consolidation				
1	Were all data added up accurately? ***Instruction*** : Check if the total number is correct, or if the number is unusually higher or lower than average.			
2	Does the report cover all information from the BHS under the ***Instruction*** : Check if the consolidation report at BHS is all available and added properly in the report.			
No. of women tracked with No. of women with MC book				
3	Is the data consistent? *(If YES, please proceed to Q5)*			
4	If not consistent, are there appropriate reasons indicated in the remark?			
No. of women tracked with No. of women with accomplished birth plan				
5	Is the data consistent? *(If YES, please proceed to Q7)*			
6	If not consistent, are there appropriate reasons indicated in the remark?			
No. of women who delivered this month with those who delivered at health facility				
7	Is the data consistent? *(If YES, please proceed to Q9)*			
8	If not consistent, are there appropriate reasons indicated in the remark?			
No. of women who delivered this month with those who completed Home Visit 4				
9	Is the data consistent? *(If YES, please proceed to Q11)*			
10	If not consistent, are there appropriate reasons indicated in the remark?			
No. of women who delivered this month with those who completed PNV4				
11	Is the data consistent? *(If YES, please proceed to Q13)*			
12	If not consistent, are there appropriate reasons indicated in the remark?			
13	Is the No. of women to be tracked next month (Column 6 - Colum 11) calculated accurately?			
B. Total				
Grand Total (A+B)				(_____%: Total marked "yes" / 12)

Assessment	V.Poor 0-39%		Poor 40-69%		Good 70-89%		V. Good 90-100%		

Performance Indicator: Review using the **latest** CHT consolidated monthly report. *(Month:* *Year:*

% of tracked women with MC	**%**	**% of tracked women with a birth plan**	**%**	**% of tracked women delivered at HF**	**%**

Other				
1	Any supportive activities conducted by the staff at RHU/DHC			
2	Any good practices related to CHT			
3	Any identified challenges or issues related to CHT activities (including CHT monthly report)			
4	Is there available record of action taken/recommendation based on the consolidated CHT monthly report during CHT meeting	Y	N	
Summary of Findings and Recommendations by the Supervisor				

Supervisor: _____

Name & Signature

Centre for Health Development - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)

Supportive Supervision at RHU/DHC - Feedback sheet

Facility:	Date:

1) Supervisors need to discuss among themselves to verify their findings, following this form
2) When all is agreed on, ask all staff who are available to attend the feedback session.
3) Obtain some additional dataas directed

Data on Naternal and Neonatal Deaths since January this year (infant death inludes neonatal deaths)

1. No. of maternal deaths		3. No. of naeonatal deaths		5. No. of infant deaths	
2. Review carrie out		4. Review carried out		6. Review carried out	

Assessment (unless indicated otherwise):
V.Good means yes, almost complete. 90- 100% Good: 60%-89% 0f questions are answered 'yes',
Poor: less the half (30-59%) was answered 'yes', V.Poor: Most are answered No (0-29%)

	Assess the followings based on check lists	Assessment	Important issues to be discussed
1	Human resources is adequate		
	BEmONC trained (No. trained)	Current no.	
	Midwives trained (No. trained)	Current no.	
	Facility in good condition, organized and clean		
	Readiness for receiving cases/ for emergency		
	LGU's commitment for drugs/supplies,forms and equipment maintenance		
	MDR being conducted (% of reviewed/deaths)	%	
	NDR being conducted (% of reviewed/deaths)	%	
	Delivery service provided and functionality of tracking system		
	LGU resolutions/ordinances implemented		
	Current PhilHealth accreditation	No/MCP/MCP+	
	PhilHealth Reimbursement (regular, sometines, never)		
2	ANC(including EDC, AOG calculation		
	Labor and Partograph		
	Immediate Postpartum care		
	Postpartum care		
	Newborn care		
3	Practices observed are correct and staff are competent		
	Signal BEmONC functions and other clinical skills are performed. (BEmONC Team)	No. Performed	
	Skills for which Midwives are trained	Skills practiced	
	Staff's knowledge level		
4	Client's satisfaction		
	Care during labor (If applicable)		
	MC Book or HBMR and Birth plan		
5	Referred cases reached to the intended facility		% or no data
	Two-ways referral system is functioning		%
	Referral were justified		%
6	Quality of CHT monthly reports		

Over all Strengths (Emphasize these, If there is a good practice, note down):	
Areas to be improved:	
In the feedback session, discuss the following together with the MHO/DHC and staff of the facility. **Invite a representative of LGU.**	
7	Give feedback stressing strengths, then areas to improve
8	Compare the feedback with the results of last SSV. If the same problem(s) persists, ask why? Still the same problem Yes ( ) Some ( ) No ( )
9	Ask to show the action plan from them last SSV. Update the situation together. If all done, congratulate. If not, analyze why. All done ( ) Partially ( ) None ( )
10	Ask to show you the action plan based on the last MNDR if any. Update the situation together. If not done, why? N/A ( ) All done ( ) Partially ( ) None ( ) No action plan made ( )
11	After analyzing all above, select a priority problem(s), which can be solved within their own capability. Priority problems for which Action plan is made. 1) 2)
12	Make a new action plan for the next 3 months. (Follow the instruction on the Action Plan)
13	For those problems beyond the capability of RHU/DHC staff, how LGU can help to solve such problems?
14	Does your hospital need to take actions to support the RHU/DHC to improve their current situation? If so, what can you do?
15	Requests to PHO/CHO 1) 2) 3)
16	Any other concern of the facility staff

Next supervision

It was agreed with RHU/Hospital teams that the next SSV will be on _____

MHO/DHO/OIC _____ Rep. Local Government: _____

Supervisors; _____

_____

_____

_____

Health development Office 8 - Eastern Visayas
Family Health Cluster
Basic Emergency Obstetric and Newborn Care (BEmONC)

Action Plan

Facility:	Date:

Preparation of Action Plan

1) Analyze the problem using 'but why' method, till all agree upon appropriate solutions.
2) Then identify actions to be taken,. The responsible person for the activity, and when they want to have it done.
3) Ensure that RHU/DHC has resources to implement the activities.
4) Prepare action plan. (To be attached)
5) For other important issues, write down what RHU/DHC, as well as DH can do and follow them up.

Use one raw for one issue. For each action, make sure you identify the responsible person, by when, and availability of resources

ACTION PLAN

Problem to be solved	Action to take	Responsible person	Time frame (by when)	Resources required	Tick if done

Add more sheets if you need.

MHO/DHO _____

Rep. Local Government _____

Annex 4: List of Supportive Supervision Training and other materials

These materials will be available on request to the Regional MNCHN Coordinator or SMACHS EV Project office situated at DOH RO 8.

1. Facilitator's Guide, Training on SSV
2. Participant's Guide. Supportive Supervision
3. SSV monitoring reporting form (to be used for summarizing SSV results)
4. SSV database (DOH8, PHO/ILHZ and Ormoc CHD level)
5. SSV reporting template